

# **Trust, Professionalism and Regulation: A critical exploration**

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# Executive Summary

## Overview

This project aims to describe and explain what values, attitudes and behaviours are required of professionals in modern society to maintain, or restore, trust and to be judged trustworthy. The project explores the concept of professional **trust**, questions what it means to be a trustworthy professional and examines these concepts in relation to **professionalism** and **regulation**.

Two professions were selected for this research, **Medicine** and **Law**, as these are hugely influential to the prevalence and continuation of social welfare (Medicine) and social justice (Law). A critical exploration of the ways in which trust in these professions impacts professionals' behaviour and how the professions are regulated, sheds light on how the enactment of professional trust can have wider societal ramifications; ultimately affecting individuals' chances in life. Trust is essential to every individual, institution and profession (O'Neill, 2002). For example, Medicine and Law possess high degrees of socio-political power which can control a member of the public's ability to participate in society: to legitimise an individual's relief from social norms and expectations (Medicine); and to prescribe what those social norms and expectations are (Law). Trust in these professions is therefore paramount because of the influence society subscribes to them and the real-world impact they have on public health and order.

Professional trust as a concept can be understood as a virtue, traditionally held in the highest regard by professionals and understood to be given to them by the public. Two recent public polls tracked trust in the medical and legal professions by asking the public to indicate whether they trusted professionals to tell the truth. According to the IPSOS MORI veracity index (2018), 85% of the public trust doctors to tell the truth and 70% trust judges. The YouGov Legal Services Consumer Tracker (2016) poll compares trust between doctors and lawyers, and reveals that 80% of respondents trust doctors to tell the truth and 42% trust lawyers. Moreover, the poll notes that the public's trust in lawyers has fallen slightly since the 2015 study (where 47% of the public reported that they trusted lawyers to tell the truth) whereas trust in doctors remains static. The differences in these results, informed our rationale for examining trust across these two 'traditional' professions.

This project aimed to reference professionals' conceptualisation of trust against two other notions: views about professionalism and professional regulation. Professionalism is a complex and shifting concept. The nature of what it means 'to be professional' requires constant re-examination because historical accounts and definitions are often inadequate in rapidly and substantially changing societal contexts. By investigating professionals' views on professionalism, this project will provide a rationale for the values, attitudes and behaviours that professionals use in modern society. Professional regulation is also critical in this contemporary re-examination of trust because the implementation and expansion of regulatory practices has been a political response to building trust in professions, achieved, arguably, through the demonstration and facilitation of transparent processes resulting in professional accountability. By unpacking the perceived and actual relationship between trust and regulation, this project explores the impact of current regulatory practices on professionals' work and decisions, and problematizes current practices to encourage audiences to consider how things could be different. Understanding contemporary notions of these three concepts - trust, professionalism and regulation - within Medicine and Law is important because both professions have a moral contract

with society to advance health and justice. The values, attitudes and behaviours medical and legal professionals hold demonstrate how they understand their societal responsibilities, and therefore provide deeper insights into the impact that of the presence (or lack) of trust can have. As result, this study will help inform the ways in which policy related to these professions can improve social welfare and social justice.

The following research questions guided and focussed our study:

- 1) What are the significant socio-political events that have impacted upon perceptions of professionalism and approaches to regulation in Medicine and Law?
- 2) In what ways do these perceptions of professionalism and approaches to regulation impact on conceptualisations of trust in these professions?
- 3) What impact do these conceptualisations of trust have on the behaviours of associated professionals?
- 4) What are the implications of the research and areas for future development?

## Theoretical framework and methodology

To explore these questions, we used Political Discourse Theory, which holds that there is no one single truth, rather that there are always multiple interpretations of reality and that social phenomena are subject to change. Political Discourse Theory purposefully recognises the role of politics and power in shaping societal discourse. This theory has been used to design the research and analyse the data, in order to characterise the relationship between trust, professionalism and regulation, and subsequently generate a critical explanation of it.

We undertook in-depth qualitative interviews with representatives from each profession. Our aim was to recruit a participant group that would provide a rich and diverse range of views, beliefs and rationales and therefore we sought participants who practised in a range of contexts, cultures and professional roles. The sample we recruited was purposeful and stratified, and included medical and legal professionals who were practitioners as well as those who were opinion formers and leaders (who made and enacted policy). A total of 30 professionals were interviewed, 15 from the medical and 15 from the legal professions.

Political Discourse Theory has a particular approach to analysing data which enables explanation, interpretation and critique. It understands that any analysis speaks only of a particular 'snapshot' of time within a particular context. Using this approach, within the data we looked for 'common sense' or normative conceptualisations of 'reality' that are implied in the day-to-day practices of interview participants; descriptions of what they believed and did, and justifications as to why; the attitudes and beliefs they reported to either challenge or defend these beliefs and practices; and the emotional and ideological reasoning that participants applied to reinforce and maintain their ways of doing things.

## The main findings

### Findings from the literature

To set the study in its context, we examined the current social-cultural context in which Medicine and Law function, understanding this to be a significant influence on the attitudes, values and behaviours required of modern professions to maintain trust. In the literature review, we considered what this socio-cultural context *is*, and drew on social theorists who argue that we live in a 'neoliberal society'; that is, a society which adopts market principles and positively progresses the ideas of competition and subsequent imbalances in equity. Neoliberalist influences have also promoted a shift to a 'managerialist' approach to professionalism, arguably eroding more traditional views on trust, with the introduction of explicit professional standards and regulation.

We also reviewed the literature to identify high-profile media events that have impacted upon trust in the professions. However, we were unable to determine which events were significant and to definitively state their impact upon trust through the literature review alone. This was because an in-depth description of the impact of these events on the conceptualisation of trust in the professions was lacking in the literature. This also meant that it remained unclear whether, and how, the values, attitudes and behaviours that are required from professionals may have shifted as a result of these events from the literature alone.

We therefore also explored our participants' perceptions of the impact of significant events, collected during our interviews, to consider how these may have influenced trust in the professions.

### Findings from the interviews

Our findings present the participants' understandings regarding the three concepts of trust, professionalism and regulation, and the attendant practices implied within their accounts.

Central ideas underpinning professionals' behaviours included:

- *The importance of trust and being trusted*
  - o There was a belief that trust is central to establishing a positive relationship between the professional and their patient/client, and thus to enable a service to be properly and effectively provided.
- *The measurable nature of trustworthiness*
  - o There was an acceptance of the belief that professionals must demonstrate professionalism to patients/clients in order to be trusted.
- *The idea of trust as an individualistic quality*
  - o Trust is largely given or earned by the professional themselves (not the profession as a whole) when the patient or client enters into a professional relationship.
- *The fragility of trust*
  - o Professionals considered that trust was delicate and that once lost, it was extremely hard to recover.



Two ideas which questioned and then reinforced these beliefs stood out as key:

- *Reinforcing the importance of trust.*
  - o Participants sometimes contested the crucial importance of public trust by repositioning this as a lesser requirement if the public have 'no choice' but to use the services of professionals. However, this was countered by the argument of the importance of trust to perform well as a professional service provider.
- *Reinforcing the importance of transparency*
  - o Participants' accounts sometimes challenged the political emphasis on demonstrating their professionalism to the regulator, however this was outweighed by the importance of evidencing the integrity and trustworthiness of the profession to the public through regulation.

Emotional or ideological beliefs shaped professionals' actual practice and included the following themes:

- *The dangers of untrustworthiness*
  - o This belief was aligned with the idea of 'bad things to come' should trust be neglected in the client/patient to practitioner relationship.
- *The assurances of regulation*
  - o This claimed that regulation not only maintained, but also promised to improve the profession.
- *The threat of regulation*
  - o This supported the belief that professional systems could not function without regulation holding professionals to account; and that without regulation, malpractice incidents would reoccur.

Finally, two social practices were identified:

- *The social practice of service provision*
  - o This conceptualised professionals to be service providers, who provided a service to their clients/patients (the service users) in a transactional way. Professionals aimed to provide an effective and consistent service through demonstrable professionalism.
- *The social practice of professional accountability*
  - o This characterised accountability as inherent to the concept of what it meant 'to be a professional' and to belong to a profession. As a consequence, professionals understood that they had to demonstrate how the service they provided met the expectations of the service user (client/patient) in a rigorous and transparent way.



*Figure 1: Similarities and differences between Law and Medicine in relation to trust*

The inner circle shows key factors contributing to the maintenance of trust of both professions, as reported by our participants. These included an understanding of the role of the professional as sharing their expertise via the provision of a service. In doing so, professionals acknowledged the fragile nature of trust and power differentials within their professional relationship with clients/patients. This relationship was regulated by strict adherence to a professional code of practice.

The outer circle shows differences in key conceptualisations and systems of trust between the two professions. Within Law, accountability to the court was a key determinant of professional behaviour, also demonstrated to clients through professional rituals and dress. Direct payment for services caused some suspicion of professionals' motives and eroded trust. Within Medicine, upholding patient safety via transparent and evidenced professionalism was paramount and closely enforced by the regulator. Public scandals threatened the trustworthy image of Medicine as altruistic and working solely in the public interest.

## Conclusions and social implications

### Impact of scandals and socio-political events

An examination of the academic literature did not reveal conclusive evidence of the impact of specific scandals and socio-political events on the professions. An in-depth evaluation of the impact of particular events on the trust in the professions and/or professionals is therefore missing and represents a substantial gap in the literature. This gap also highlights the originality of our approach, whereby we sought the perspectives of those currently working within, or allied to, the professions of Law and Medicine, in relation to this topic.

There was a noticeable difference between how medical and legal participants positioned high-profile events within their professions. Law scandals were predominantly seen to be finance related, reinforcing a perception that Law is a financially orientated profession; whereas in Medicine, scandals related to high-profile malpractice events where exposure and disposal was justified in relation to the greater risks at stake (a loss of life, rather than a financial loss), as well as crucially, a threat to the trustworthy image of the profession. Medical participants were vocal about the need for rigorous regulation to proactively remove mal-practicing individuals - 'bad professionals' - so that they did not harm patients or damage the overall altruistic image of the profession.

Some events were cited more frequently than others, particularly in Medicine. Some events were understood to have precipitated changes such as increased regulation, especially within Medicine. However participants did not perceive that any one event had radically shaped the professions in a completely new direction. Rather, it seemed that high-profile events had further reinforced their acceptance of neoliberalist values (e.g. transparency, individual accountability and responsibility, increased regulation) within their practice.

### Trustworthy attitudes, values and behaviours

In their accounts, participants clearly divided up those who adhered to 'professionalism' and could thus be trusted (the 'good professional') and those who did not (the 'bad professional'). Professionalism was conceived of as a demonstrable and assessable quality, whereby 'good professionals' were able to evidence their professionalism, whereas 'bad professionals' could not. We suggest that the neoliberal obligation for evidenced, rather than ideologically based, judgements drove this belief.

The importance of maintaining trusting professional relationships with clients and patients, through demonstrating appropriate attitudes, values and behaviours was stressed by participants. Professionals understood that, if trust was lost, clients/patients would be reluctant to honestly confide in them and would stop seeking advice from them. This would substantially impede their ability to perform their services to that client/patient. Moreover, participants' narratives contained concerns about the serious detrimental effects of a loss of public trust in the wider professions. Participants described the anti-vaccine movement, a resurgence of disease and poor public health, social unrest and disruption as examples of the consequences of a loss of public trust in traditional professional institutions and norms.

## The impact of regulation on professionalism and trust

The extra pressure of patient safety and the altruistic image on those within the medical profession to establish themselves as 'good professionals' in order to maintain trust resulted in an increased reliance on the need for external validation of 'professionalism': this was accomplished by the regulator.

Participants reported that the self-regulation of the professions was important and widely used, and that, although this may be adequate for 'good professionals', external regulation was necessary to remove and remediate 'bad professionals'. Professionals at all levels and in a wide range of roles, thus argued that regulation was a necessary addition to self-regulation. This was justified from the point of view of the public, who they accepted would never see self-regulation as legitimate or effective. The need for external regulation, even if just to reassure the public, was therefore presented as necessary.

Within both professions, participants cited the benefits of increased regulation to increase public trust. In tandem, their accounts threatened that professional systems would not function without regulation to maintain trust within the professions. These benefits and threats were thus used to reinforce the necessity of the regulator as a guardian of trust in the profession, positioning regulation as inherently tied to trust within the professions.

## The impact of trust on professional behaviour

Participants deemed trust as crucial, seeing it as fundamental to the functioning of their 'service' and the satisfaction of both client/patient and practitioner. Accordingly, the highly valued identity of a 'good professional' was characterised as someone who could create and maintain trust in professional relationships.

Participants recognised that, although scandals might shake the trust in the profession as a whole, trust in the individual professional could be almost totally disassociated with this. This understanding of trust as an individualistic quality - established through relationships between individuals – meant that participants perceived it as still possible to maintain trust within their own practice, even if trust in the wider profession was challenged (e.g. the anti-vaccine movement in Medicine, or the perception of 'ambulance chasers' in Law). This was vital as it was understood that, once lost, trust was extremely difficult to rebuild.

We therefore suggest that establishing trust through professional relationships might be considered a 'protective force' for individual professionals, as well as a facilitator to effective practice. Both these reasons encouraged participants to prioritise behaviours which underpinned 'trust' in them as a professional.

## Recommendations for research

The comparative approach (between Medicine and Law) greatly aided analysis and helped bring unexpected findings to light. These two well-established and prestigious professions shared key commonalities in relation to conceptualisations of ‘trust’, as well as marked differences. Future research into trust, professionalism and regulation could utilise this comparative approach. Comparisons which included the ‘newer’ professions (e.g. Nursing, Engineering, Piloting etc.) and compared these to the ‘traditional’ professions (e.g. Law, Teaching, Medicine etc.) would be particularly interesting. International comparisons of the same profession across differing contexts may also usefully illuminate context-specific differences.

Furthermore, it would be interesting to investigate ‘trust’ in the professions from the point of view of the ‘service user’, (clients and patients). This might reveal interesting and useful comparisons to understand both how ‘trust’ is understood to be ‘received’ and built from this viewpoint.

## Concluding Statement

Professionals and their regulators should critically consider the impact of modern society (neoliberal structures) and associated conceptualisations of ‘trust’ on their professions, and everyday practice. The individualistic conceptualisation of trust may be protective for ‘good professionals’ who are buffered from wider challenges to the image of the professions as a whole and can continue to forge trust relationships with patients and clients unhampered. However, for medical professions particularly, this concept is predicated on a need to ‘evidence’ that one is a ‘good professional’ through intensive and continual regulation. This currently creates an increasing dependency on the growing ‘trust-industry’ of regulatory bodies and systems. However, and interestingly the legal profession runs largely without this supporting ‘industry’. Although Medicine functions within a different context and under an increased perception of risk, increasingly strong regulation is not the only possible response – just one of many. In this project we have exposed professionals ‘ways of thinking’ that have brought about the current situation and structures, and work to reinforce these as assumed and unquestioned. With these understandings revealed, we encourage audiences to consider how these might be different, and improvements changes might bring.

# Chapter 1: Introduction

## 1.1 Rationale

The project aim is to describe and explain what values, attitudes and behaviours are required of professionals in modern society to maintain, or restore, trust and be judged trustworthy. The project explores the concept of trust, questions what it means to be a trustworthy professional and examines these concepts in relation to professionalism and regulation.

The two professions selected for this research (Medicine and Law) are hugely influential to the prevalence and continuation of social welfare (Medicine) and social justice (Law). The critical exploration and understanding of the ways in which the regulation of, and trust in, these professions impacts their behaviours, also begins to shed light on how the enactment of professional trust can have wider societal ramifications; ultimately affecting individuals' chances in life. Medicine and Law possess high degrees of socio-political power which can control a member of the public's ability to participate in society. For example, these professions possess the power to legitimatise an individual's relief from social norms and expectations (Medicine); and the power to prescribe what those social norms and expectations are (Law). Therefore, trust in these professions is paramount because of the hegemony society subscribes them and the real-world impact they have.

Understanding contemporary notions of these three concepts - trust, professionalism and regulation - within Medicine and Law is important because both professions have a moral contract with society to advance health and justice. The values, attitudes and behaviours of medical and legal professionals demonstrate how they understand their societal responsibilities, and therefore provide deeper insights into the impact that the presence (or lack) of trust can have. As result, this study will help inform the ways in which policy related to these professions can improve social welfare and social justice.

The following research objectives and questions focussed our study:

### 1.1.1 Research Objectives

- 1) To critically explore historical socio-political events that have impacted on perceptions of professionalism and the role of regulation in relation to trust in Law and Medicine. To understand the historicity of current ideas and beliefs about 'trust' and how it relates to 'professionalism' and 'regulation'.
- 2) To describe the attitudes, values and behaviours of the modern professional required to maintain trust in current socio-cultural contexts. To outline what the 'reality' of 'trust in professionals' is now, and what logics underpin and sustain these beliefs.
- 3) To evaluate the social implications of the research findings and highlight areas for future research. To identify what broader 'reality' ideas about 'trust in professionals' reify and what this might mean.

### 1.1.2 Research questions

- 1) What are the significant socio-political events that have impacted upon perceptions of professionalism and approaches to regulation in Medicine and Law? To be identified via a comprehensive literature review and discussions with participants.
- 2) In what ways do these perceptions of professionalism and approaches to regulation impact on conceptualisations of trust in these professions? To be identified from discussions with participants.
- 3) What impact do these conceptualisations of trust have on the behaviours of associated professionals? To be identified from discussions with participants.
- 4) What are the implications of the research and areas for future development? To be explored in the concluding discussion of the report.

## 1.2 Background and Concepts

This research takes a detailed look at crucial but complex social phenomena. Trust, professionalism and regulation are mutable concepts. Each lacks a precise definition, further complicated by the fact that they are interpreted variably by different professional and public communities, and therefore definitions are contextually bound. Of particular relevance to this study is the issue that discourses around trust, professionalism and regulation are dynamic. Taken together, this means that there are multiple ways to understand these concepts, and that these understandings are not fixed and are instead subject to constant change. The literature review (Chapter 3) will unpack the notions of trust, professionalism and regulation within Medicine and Law in detail, and therefore this section will instead provide a brief contextualisation for the study.

### 1.2.1 The concept of Trust

Trust is an important aspect of all interpersonal relationships. Trust, and the commitment not to break it, is considered a fundamental professional virtue, necessary to acting professionally and positioned as universally understood across contexts (El-Eraky et al 2015; Ludmerer 1999). Yet, when we come to define trust more precisely it becomes problematic.

The Cambridge dictionary (2019) defines trust in the following way: “to believe that someone is good and honest and will not harm you, or that something is safe and reliable”. However, others posit trust in terms of behaviours, emotions and rationalisations (e.g. rationalising the probability that harm will not occur or referring to feelings, for example of confidence or dependability).

Regardless of its definition, trust is a virtue held in the highest regard by professionals. Later in this report, the significance placed upon trust as documented in professional codes of conduct will become clear. Trust is also endowed on professionals by the public. Two public polls tracked trust in the medical and legal profession by asking the public to indicate if they trust professionals to tell the truth. According to the IPSOS MORI veracity index (2018). 85% of the public trust doctors to tell the truth and 70% trust judges. The YouGov Legal Services Consumer Tracker (2016) poll compares trust between doctors and lawyers, and reveals that 80% of respondents trust doctors to tell the truth and 42% trust lawyers. Moreover, the poll notes that the public’s trust in lawyers has fallen slightly since the 2015 study, in which 47% of the public reported that they trusted lawyers to tell the truth, whereas

trust in doctors remains static. The differences in these results, according to the regimes of practice (roles) and historicity (time) adds a further rationale for examining trust across these two ‘traditional’ professions.

### 1.2.2 The concept of Professionalism

Professionalism is concerned with *how* individuals conduct their professional life. Definitions of professionalism frequently describe a set of agreed, desirable and demonstrable attitudes, values, behaviours and relationships that a professional should exhibit. It is widely regarded that the display of these attributes, and thus ‘professionalism’, underpins public trust.

However, professionalism is a complex and shifting concept. The literature highlights the difficulties in providing a universally recognised definition, which fully accounts for the range of political, economic, societal and stakeholder requirements regarding professionalism (Wagner et al. 2007; Hodges et al 2011; Birden et al. 2014). An important aspect of contemporary professionalism is the requirement to account for the value-pluralism that is found across the societies in which we live, in order to develop a fully realised professionalism. The shifting nature of what it means to be professional also requires constant re-examination because historical accounts and definitions are often inadequate in rapidly and substantially changing societal contexts.

As a concept, professionalism is closely associated with ‘trust’ and ‘regulation’: (i) regulation supposedly measures, assesses and achieves/ensures professionalism; and (ii) professionalism (arguably determined by regulation) supposedly earns or assigns trust in professionals.

### 1.2.3 The concept of Regulation

‘Regulation’ (the implementation and expansion of) has been a standard response to building trust in professions, through the demonstration and facilitation of transparency and accountability. By unpacking the perceived and actual relationship between trust and regulation, this project explores the impact of current regulatory practices on professionals work and decisions, and problematizes current practices to question how regulation might be conceived of differently.

## 1.3 Report Outline

Following this introduction (Chapter 1), this report contains the following sections:

- 1) The methodology chapter (Chapter 2) presents the research approach. The research has been understood through the lens of Political Discourse Theory (PDT). PDT holds that there is no one single truth, rather there are always multiple interpretations of a social reality and that social phenomena undergo change over time. It purposefully recognises the role of politics and power in shaping societal discourse. This theory has been used to design the research and analyse the data, in order to characterise the relationship between trust, professionalism and regulation, and subsequently generate a critical explanation of this relationship. The critical nature of the analysis permits the identification of the causal mechanisms which may make



this relationship possible. This includes a consideration of the historical context and utilises the self-interpretations of relevant social actors.

The participant group was purposefully selected and stratified, and aimed to recruit medical and legal professionals who were practitioners, as well as those who were opinion formers and leaders in the areas of interest. Key opinion formers and leaders included representatives from academia, policy, and professional regulation, who represented various regimes of practice and included lay commentators. Data was collected using in-depth one-to-one semi-structured interviews.

- 2) The literature review (Chapter 3) describes the macro, meso and micro factors that have influenced trust in Medicine and Law throughout modern history. The wider socio-political and socio-cultural influences are critically examined to set the research within its social context. A review of the contemporary academic literature based on ideas of trust, professionalism and regulation in Medicine and Law, as well as policy documents from these professions, helps to explain whether, how, and why the current design and operation of policy may be problematic. The review also encompasses an overview of high-profile socio-political events and scandals that may have influenced levels of trust in the professions.

Chapter 3 concludes by drawing together the review findings into a 'problematism statement' which summarises these together and conceptualises these as a problem. This 'problem' is then used in the subsequent chapter to analyse the interviews, with the aim of examining and questioning existing practices.

- 3) The Results (Chapter 4) presents a description of the study participants and a poststructuralist discourse analysis focussed on the concept of trust and following the 'logics approach'. In total, 30 participants took part in this study: 15 working within, or related to, the medical profession; and 15 working within, or related to the legal professions. The analysis begins by discussing the social, political and fantasmatic logics related to trust, exploring how these interdigitate with professionalism and regulation. These logics help demonstrate how participants' beliefs are understood and how these ideas inform the activities that construct their everyday social practices. We discuss the importance of trust as a prerequisite for practice, how professionals demonstrate trust through behaviour, language and visual clues and the importance of competence. We go on to talk about the individualistic versus systemic relationship of trustworthy relationships: that 'trust in the profession' is tangibly different from 'trust in an individual professional'. We explore the fragility of trust in both Medicine and Law, finding important and significant differences between the two professions caused by the context and practices of their work. The analysis of political logics foregrounds vulnerability and issues of choice regarding professional encounters and highlights the role of marginalising or removing untrustworthy professionals through regulation. Fantasmatic logics identify the 'horrible promises' that our participants associated with mistrust, unprofessional behaviour and regulation. Only regulation provides 'beautiful promise' of improving professional standards and maintaining trust in the professions. We conclude with an exploration of how our participants' ways of thinking about trust, professionalism and regulation impact on actual work: the reality of professional practice.

- 4) Chapter 5 discusses the findings, social implications and possibilities for future research. This chapter begins with a summary of the research findings, ordered to address each of the research questions. First we examine the impact of socio-political events on trust in the professions, drawing out the significant differences between Medicine and Law. An in-depth analysis of the impact of particular events on trust in the professions and/or professionals reveals a substantial gap in the literature. We then discuss the conceptualisation of trustworthiness and summarise its impact on attitudes, values and behaviours. Discourses strongly divided those who adhered to 'professionalism' and could thus be trusted (the 'good professional') and those who did not (the 'bad professional'). We move on to discuss the impact of regulation on professionalism and trust, as well as the impact of trust on professional behaviour. The need for external regulation, even if just to reassure the public, was presented as necessary, although aspects were perceived as problematic. The final section of the report discusses the social implications of the research, and recommendations for future projects.

## Chapter 2: Methodology

### The logics approach to discourse analysis: theory and method

#### 2.1 Origins and ontological underpinnings

In order to explain and outline the logics approach to critical explanation (Glynos et al., 2009) that was used to both design the research project and analyse the data, it is first necessary to understand the ontological suppositions that underpin it.

The logics approach to discourse analysis draws on Political Discourse Theory (PDT) to offer a research ethos for data collection and analysis. PDT refers to the post-structuralist, post-Marxist theory of Ernesto Laclau and Chantal Mouffe (1985) (which has been developed and expanded by subsequent works and scholars in the years since its publication). In essence, PDT draws on the works of Gramsci and Althusser to tackle the problem of essentialism (Glynos et al. 2009); the idea that “a society, human subject, or the objects that we encounter in social life, have fixed essences that exhaust what these entities are” (Glynos et al. 2009, p7). In contrast, PDT draws on the writings of Foucault, Derrida, Lacan, and Žižek, to stress the *contingency* and *historicity* of ‘reality’ and emphasise the primacy of politics and power in its formation (Glynos et al. 2009).

Within PDT ‘discourse’ is understood to have four key features:

- 1) It is a shared way of understanding, and making sense of, the world that assigns meaning and significance to objects;
- 2) Subjects of discourse acquire meaning only in relation to the others;
- 3) That all meaningful structures (like states or governance networks) “can be conceptualized as more or less sedimented systems of discourse, that is, partially fixed systems of rules, norms, resources, practices and subjectivities that are linked together in particular ways” (Glynos et al. 2009, p8);
- 4) That all discursive objects are *radically contingent* and can be interpreted and understood in many different ways. As a result, it is understood that there is no objective, discoverable, *reality*; only a temporal ‘*reality*’ - and this should be understood and critiqued, not uncovered.

This understanding - that ‘*reality*’ is understood to be contingent, and that ‘knowledge’ is understood to be able to be ‘known’ only at a specific moment in time - is a key perspective the logics approach and offers to the explanation and study of society (when compared to other methodological approaches). For the social scientist, the logics approach is thus a unique analytical approach, which enables explanation, interpretation and critique. As we shall come to discuss, the approach incorporates the self-interpretations of social actors without simply reducing explanations to subjective viewpoints, and enables an explanation of phenomena that recognises the specificity of the case under investigation, while also providing a level of generality and space for critique (Glynos & Howarth, 2007).

These ontological suppositions also structure the logics approach’s *problem-driven* approach to analysis. The approach is ‘problem-driven’ as it constructs ‘problems’ and explains these in specific historical contexts, in order to question: the origins of particular discourses (shared ways of

understanding); how these are characterised; how and why these are sustained; when and how these are changed; and how these can be evaluated and criticized (Glynos et al. 2009). Explaining these 'problems' thus helps develop and understanding of the 'conditions of possibility' through which these came to be, and are either maintained or challenged. In essence, this approach thus constructs an ideological space to describe, explain, criticise, and evaluate phenomena, and offers a variety of tools to do so. That said, Glynos & Howarth (2007) are careful to note that these tools do not constitute a clear-cut method, nor a normative evaluative or analytical framework. Instead, they position the logics approach as a 'research ethos' that constructs and furnishes answers to empirical problems.

With this in mind, the next section will outline the various implements of this 'toolbox' and explain how these have been utilised in this project.

## 2.2 A logics approach to exploring 'trust': a (brief) summary

### 2.2.1 'Reality' as the object of retroductive social inquiry and explanation

As alluded to above, an important 'tool' employed in this project is the poststructuralist, post-Marxist ontological supposition that social scientific inquiry should not be concerned with revealing an 'object reality' which exists external to thought (because such a thing does not exist). Instead, social scientific inquiry should be concerned with understanding the 'conditions of possibility' of a particular 'reality' at a specific moment in time (because this is all that there is, and all that there can be). This 'tool' has enabled us to develop and refine our research objectives and questions:

#### 2.2.1.1 Research objectives

- 1) To critically explore historical socio-political events that have impacted on perceptions of professionalism and the role of regulation in relation to trust in Law and Medicine. *To understand the historicity of current ideas and beliefs about 'trust' and how it relates to 'professionalism' and 'regulation'.*
- 2) To describe the attitudes, values and behaviours of the modern professional required to maintain trust in current socio-cultural contexts. *To outline what the 'reality' of 'trust in professionals' is now, and what logics underpin and sustain these beliefs.*
- 3) To evaluate the social implications of the research findings and highlight areas for future research. *To identify what broader 'reality' ideas about 'trust in professionals' reify and what this might mean.*

#### 2.2.1.2 Research questions

- 1) What are the significant socio-political events that have impacted upon perceptions of professionalism and approaches to regulation in Medicine and Law? *To be identified via a comprehensive literature review and discussions with participants*
- 2) In what ways do perceptions of professionalism and approaches to regulation impact on conceptualisations of trust in Medicine and Law? *To be identified via a comprehensive literature review and discussions with participants*
- 3) What impact do these conceptualisations of trust have on the behaviours of associated professionals? *To be identified from discussions with participants*

- 4) What are the implications of the research and areas for future development? *To be explored in the concluding discussion of the report*

In employing this research ethos we accept the notion that social and political sciences cannot uncover reality truths, as such truths don't exist. Thus, this research project is not concerned with definitively stating, or determining the 'truth' of, what "trust" is and how it relates "professionalism" and "regulation". Nor is it concerned with definitively stating, or determining the 'truth' of, what can be done by a professional to build or diminish "trust" or what impact the presence or lack of "trust" has for professionals. Instead, the project is concerned with exploring "trust" as a concept, as it is understood at this specific moment in time. Acknowledging the importance of the past on the present, the study explores how this idea of 'trust' has come to be, and what impact *this specific idea of 'trust'* has on those in the professions.

### 2.2.2 Problematisation

The logics approach begins with a process of compiling a range of disparate empirical phenomena together and conceptualising them as a problem. The problem is then located at the appropriate level of abstraction and complexity (Glynos et al. 2009). We develop our problematisation in the next chapter of this report, following (and informed by) our comprehensive literature review. However, it is important to note here that this *problem-driven* approach should not be confused with a *problem-solving* approach – as problem-solving research "tends to take for granted the existence and nature of certain social structures or rules, as well as the assumptions of the dominant theories of such reality, and then operates within them" (Glynos et al. 2009, p10). In contrast, a *problem-driven* approach questions and challenges such structures and rules, as well as the assumptions of the dominant theories of reality. Thus, this approach does not seek to solve the 'problem' identified in the next chapter; instead to draw attention to this phenomena, along with the complexities and contradictions involved with it, and seek to understand it in terms of what makes it possible.

This approach to research can have significant impact in relation to the academic and policy agendas of the field. By 'opening up' and questioning existing practices, the PDT approach taken in this project creates the critical ideological space necessary to *consider* implementing change(s), but with the recognition that doing so will then change, rather than eradicate, problems within the new formations of meaning that are created as a result.

### 2.2.3 Contextualised self-interpretations

The logics approach attests that "our interpretation of 'reality' is *constitutive* of reality, not merely a view *on* reality" (Glynos & Howarth 2007, p55). Therefore, to study society, it is crucial to understand the perspectives of the social actors that construct and sustain it; to gather social actors' self-interpretations of 'reality'. This must be done with the recognition that these interpretations are shaped by a broader socio-political context; a broader 'reality'; a broader *discourse*. It is the task of the researcher to contextualise the self-interpretations of social actors – identifying what makes such interpretations possible. The research team debated and negotiated four types of "relevant social actors" to identify participants for this project (See Table 1, p.89). Details about the approaches and practicalities involved in gathering and interrogating the data are discussed in detail in section 2.3 (p.24).

## 2.2.4 Ontological framework

Underpinning their logics approach is an ontological framework that Glynos & Howarth (2007) developed by drawing on Laclau & Mouffe's (1985) notion of a 'discursive field'. They use this notion to construct an ontological framework that understands 'reality' as essentially consisting of, and being represented by, observable and meaningful social and political practices. As a consequence, 'reality' consists of the clustering together, and interlinking, of social and political practices which, when combined, form specific regimes of practices (or 'discourses') that present a specific idea of the social world. This idea of the social world (or 'reality') is *implied* by these regimes of practices (or discourses) and can be characterised and explored by understanding the social, political, and fantasmatic logics that underpin such practices. The next sections will briefly outline what is meant by the terms 'social practices' and 'political practices'. We will then explain what is meant by the terms 'social', 'political', and 'fantasmatic logics' and how they will help to understand any social and political practices we identify in the data.

### 2.2.4.1 Social and political practices

Social practices are "largely repetitive activities that do not typically entail a strong notion of self-conscious reflexivity... they are (usually) carried out without it even occurring to someone to put into question the rules animating these practices" (Glynos & Howarth 2007, p104). They are thus things that we do, without really considering why we do them. This is because social practices, such as this are "inscribed on our bodies and ingrained in our human dispositions" (Glynos & Howarth 2007: 104). Crucially, regardless of their intentions, social practices "contribute to the reproduction of wider systems of social relations" (Glynos & Howarth 2007: 104), in the sense that they reproduce the 'reality', and systems of relations that these present simply by not challenging or questioning it. Establishing the social practices of a 'reality' can be understood as providing a snapshot of what the 'reality' structure *is*.

Political practices are more complex than social practices and have a more specific purpose. In essence, political practices work to challenge or maintain the status quo of 'reality' by either revealing or concealing the contingency of 'reality'. Typically, the contingency of 'reality' is concealed within its social practices (through social and fantasmatic logics, which will be discussed later in this chapter) but on occasion, such contingency is revealed during what Laclau & Mouffe (1985) call a moment of dislocation. Such moments are disruptions to the status quo; they are moments when the 'facts' and 'truths' that shape and inform 'reality' are disproved, revealed as false, questioned, or challenged in some way. These disruptions are such because they reveal these 'facts' or 'truths', and so 'reality' as simply one way of conceptualising the social world. It is in this moment of dislocation that political practices come to light, as political practices work to "decontest" (Glynos & Howarth) or counter these disruptions by making the 'reality' being disrupted *uncontestable*. This process of making 'reality' uncontestable is achieved by either transforming the 'fact' or 'truth' being contested, or by discrediting or making impossible the alternatives being offered.

### 2.2.4.2 Social, political, and fantasmatic dimensions and logics

As already mentioned, social, political, and fantasmatic logics underpin social and political practices. They are the logics that 'make possible' these acts these observable phenomena. Glynos & Howarth (2007) attest that 'reality' is, in essence, a regime of practices compiled from a number of social and

political practices. They go on to identify three dimensions of 'reality': 1) social 2) political and 3) ideological and ethical; and each of the three logics correspond to each of these dimensions.

The social dimension is essentially the 'status quo'; it is "reality". That is to say, in the social dimension the contingency of 'reality' is not revealed, addressed or known. The social dimension simply is; in the social dimension, 'facts' and 'truths' are "facts" and "truths". Social logics are closely associated with the social dimension and are understood to "enable us to characterise practices in a particular social domain" (Glynos & Howarth, 2007, p133). They are the 'common sense' or normative conceptualisations of 'reality' that are implied in the day-to-day practices of social actors. They can be considered as 'rules' which, when identified and deconstructed, enable us to describe and characterise specific realities (or formations of regimes of practices).

The political dimension can be considered as the dimension of 'reality' that makes the social possible. In the political dimension the contingency of 'reality' is known, even acknowledged, but it is concealed or contested in some way. Political logics are closely associated with the political dimension and are, in essence, attitudes and beliefs about social practices that either challenge or defend them during the process of decontestation (when the status quo is challenged in some way). Typically, they are revealed following a moment of dislocation. Political logics typically take one of two forms (and both can often be found operating together):

- 1) Logics of equivalence take the disrupted practice or belief and the alternative practice or belief, and highlight the similarities between the two; reducing their apparent oppositional status to a comparative one. This has the effect of transforming the existing status quo, rather than changing it
- 2) Logics of difference take the disrupted practice or belief and the alternative practice or belief, and highlight the differences between them; necessitating an either/or scenario for the status quo – either keep as is, or replace with the alternative.

The ideological-ethical dimension can be considered as the explanation for why the social is. In the ideological and ethical dimension, the attitudes and beliefs of the status quo are made necessary, or appealing, in some way in order to 'grip' people to this presentation of reality. Fantasmatic logics are closely associated with the ideological-ethical dimension and are, in essence, an ideological fantasy that decontests challenges to, and works to sediment further, the relationships between concepts and people that together constitute the structure of 'reality'. Fantasmatic logics typically take one of two forms (and both can often be found operating together):

- 1) A beautiful promise – a promise of something desirable to come should an action be taken, or a belief be adopted
- 2) A horrific promise – a promise of something undesirable to come should an action not be taken, or a belief not be adopted

During the analysis of the data collated for this research project, we will first seek to identify the social and political practices related to trust, professionalism, and regulation. Having done so, we will then seek to identify the social, political, and fantasmatic logics that make these practices possible. This analytical process is described in more detail in the sections below.

## 2.3 Practical application of the logics approach

### 2.3.1 The approach and rationale in summary

Within this analytical framework, 'trust in professions' can therefore be understood as a constellation, or regime, of social and political practices. In turn, this has implications for the explanations that we seek to offer in this research project, which explores the concept of trust as it currently exists within the professions of Law and Medicine, and how it has come to be.

As previously shown, to critically explain the emergence of a regime of social and political practices it is necessary to first characterise this regime by its component parts. In other words, to truly understand social phenomena, it is crucial that these phenomena are deconstructed in a way which identifies the component parts of the 'reality' that is presented. Each component part must then be critically accounted for (i.e. the history of the 'reality' presented must be understood). This provides the opportunity to develop an 'of-the-moment' explanation of *how* 'trust in the professions' currently *is*, by identifying the social, political and fantasmatic logics that maintain these historically produced ideas and beliefs about 'reality' *in the present*.

We thus employ this approach with the expectation that this project will contribute towards wider debates about the appropriateness and impact of 'trust', 'professionalism' and 'regulation' of professions and contribute innovative insight into a growing body of work into trust in professions. As far as we are aware, and following our comprehensive literature review (see Chapter 3), the application of the logics approach methodology to this topic (the concept of trust in Medicine and Law) is novel and thus offers an original contribution to the field. The approach also has the potential to inform and advance understanding, policy and practice, through highlighting and challenging 'taken-for-granted' but problematic aspects of current thinking, structures and practice, which could otherwise be perpetuated and reinforced.

The arguments discussed, however, remain concerned with the analysis *of* ideas, rather than analysis *for* ideas. It is therefore important to achieving our research aim, that this approach: 1) incorporates the self-interpretations of social actors without reducing their explanations of reality to simply subjective viewpoints; and 2) enables the development of an explanation of phenomena that recognises the specificity of the case under investigation, but also provides a level of generality and space for critique. These aspects are crucial to prevent the production of an opinionative narrative, and to make possible a descriptive explanation instead – a descriptive narrative that relates social phenomena to the wider context in which they exist/take place.

The practical steps taken by the research team to ensure that events were critically explained at both a micro and macro level (rather than simply interpreted), and also considered within their wider social and societal contexts, are described in detail in the Data Analysis section below. Throughout, the team was aware that the phenomena under investigation constituted component parts of a wider temporal 'reality'; and that beliefs about 'trust' in relation to professionals is both a phenomena in its own right and a part of a wider social 'reality'.



### 2.3.2 Data Collection

Six members of the research team were involved in constructing the structured approach to data collection (LK, JT, AG, KA, CO, JD). This included identifying and refining the sample frame, developing the research sample and collecting the data. This process was informed by both the logics approach and previous research experience, and considered within the time restraints on the project.

#### 2.3.2.1 Research sampling frame

As this research project was tasked with examining ‘trust’ in the context of both the medical and legal professions, the team began planning the practicalities of the research with a broad description of the sampling frame – i.e. medical and legal professionals. The research team therefore, first agreed to define (and refine) the categories of “medical professionals” and “legal professionals” in the context of this study, in order to ensure optimal relevance, quality and diversity in the participant group, within practical restraints:

Medical professionals were defined as: “medics” (i.e. practicing doctors); as well as those involved with the regulation and assessment of medical professionalism (e.g. individuals who have worked with the medical regulator (The General Medical Council (GMC)) or have taken on supervisory roles (such as ‘Responsible Officer’ in the NHS)).

Legal professionals were defined as: barristers (any specialty); solicitors (any specialty); and those involved with the regulation and assessment of legal professionals’ professionalism.

#### 2.3.2.2 Research sample

Within qualitative research, the target number of participants is determined by the aims and scope of the study (Willig, 2001). Within this study, we aimed for a sample which would provide a rich diversity of views from participants experiencing a range of contexts, cultures and professional roles, in order to explore and understand both the breath and complexity of participants’ believes and rationales. Following discussions during research planning meetings, and in drawing on the team’s research expertise, a sample size of 30 participants was agreed to be an adequate size.

The participant group was designed to be stratified, to include professionals who worked in wide range of roles within their profession. As alluded to in section 2.2.3, the research team debated and negotiated four types of “relevant social actors” from each of the professions, and agreed that these groups should be included in the research sample where possible. A description of each category of social actor, and the intended number of interviewees from each category to be included, is detailed in Table 1 (p.89). The research team searched for potential participants via author lists and reference lists in the recent literature and by searching the webpages of relevant professional, policy and regulatory organisations. Potentially relevant participants were invited to participate. The researchers also used their extensive professional networks to identify relevant individuals known to the team to be contacted with an invitation to participate. Once participants had finished their interview, they were asked if they would be happy to contact others within their networks to invite them to participate (snowballing).

When recruiting the participant group, the research team was conscious to include professionals working, not only in a range of roles, but also at various levels of seniority. Details of the group were logged in a secure location, so that the characteristics of the developing group could be tracked.

Consequently, when inviting further participants, the group sought out those to achieve maximal variety and balance within the group.

It is important to note here that individuals participated with the understood purpose of sharing their personal views and experiences of 'trust', 'professionalism' and 'regulation'. Individuals were asked to provide personal views, and not speak on behalf of the organisation to which they were affiliated. Personal views were preferred because these allowed us to explore how individuals conceived of trust during their everyday thoughts and practice, and thus to interrogate the construction of their 'reality' in relation to these concepts (rather than a repetition of organizational policy or doctrine). The participant group was thus designed to include individuals from various organisation to better understand context; not to collate the organisations' official stances on these concepts.

### 2.3.2.3 Method of data collection

Social actors' contextualised self-interpretations were best collated via semi-structured, in-depth, one-on-one interviews.

As this project involved human participants, it was essential that their well-being and dignity was preserved throughout. The research team thus took several steps to ensure that the highest ethical standards were maintained throughout the project and that any potentially detrimental effects on participants were not left unforeseen and thus unplanned for (King and Horrocks, 2010). Prior to data collection taking place, this study was granted full ethical approval by the UCL Ethics committee, ID number 13311/002.

Prospective participants were emailed a standardized invitation letter inviting them to participate, and a detailed information sheet. Participation in the study was entirely voluntary, and participants were invited to ask any questions, and made aware that choosing not to participate would not be detrimental to them in any way. The research team were aware that the disclosure of a participant's identity might cause substantial distress and could jeopardise their relationship with those within their institution/profession and or with their patients or clients. Moreover, we wished participants to speak freely about the concepts of interest, from their own personal viewpoint (rather than the formal line of their institution) and feel comfortable and uninhibited to do so. Participants were thus made aware that their data would be fully anonymised prior to publication and that all their personal details would be kept confidentially and securely according to UCL procedures.

Before data collection took place, all participants provided written consent to participate, and were informed that they could choose to withdraw from the study until a given date (after which their data would have been written into this report).

Interviews were primarily conducted via telephone at the participants' request. This was often practical for both parties, enabled researchers to conduct multiple interviews on the same day, and also enabled those based outside of London to more easily take part. Some participants requested a face to face interview and where this was possible, this request was accommodated.

Participants were asked open-ended questions to investigate their understandings of trust, professionalism and regulation (see Appendix 1). Interviews were semi-structured to allow participants to introduce new topics or focus on particular aspects as they wished. During training, interviewers were encouraged to use the set of questions (Appendix 1) as a guide, rather than a

prescribed script and to seek and probe for depth and clarity in participants' answers, rather than to cover the breadth of topic more superficially. This included probing their answers for further explanation, gently challenging participants to define or explain opinions in more depth, and asking them to elaborate via providing examples. Provided meanings and understandings were 'spoken back' to participants for confirmation and elaboration.

Four members of the research team were involved in the data collection process (LK, KA, AG, CO). All interviews were audio-recorded. Audio-recordings were sent to a professional transcriber and conversations were transcribed verbatim. These transcriptions constituted the data that was analysed for this research project. The following section details the analytical approach.

### 2.3.3 Data analysis

Four members of the research team were involved in the analysis of data collated in this study (LK, KA, AG, CO, SA). The analysis of data was broken down into two stages. The first stage involved identifying shared ideas, beliefs, values, attitudes, and behaviours across the data set. To achieve this, four team members (LK, KA, AG, CO) thematically inductively coded the same four transcripts separately. Thematic analysis allows for the patterns to be identified in the data, and for these to be meaningfully organised and linked to highlight relationships between themes (Braun and Clarke, 2006). At this point, coding was done inductively (using a data-driven approach – see e.g. Miles et al. (2013)) so that all data was coded as inclusively as possible. The independent coding of transcripts by each of the researchers, challenged the team to critically assess how their own biases and judgements might have influenced their coding, and is thus a rigorous way to improve the confirmability of the codes applied (King and Horrocks, 2010).

The research team then met to discuss their coding and ideas, and used this preliminary coding to develop a coding framework. This coding framework was then used to deductively code the remaining 26 transcripts – a task that was shared amongst the research team (LK, KA, AG, SA, CO) including an additional member of staff (BF). Throughout analysis, the coding decisions were discussed and critiqued amongst the research team, in order for interpretations to be challenged and alternative viewpoints on the data to be considered (Lodico et al., 2010). These critical discussions were undertaken under the understanding that if any team member identified a need to revise the coding framework, a research team meeting would be called to discuss this (thus allowing it to remain sufficiently flexible to adapt to unexpected insights (King and Horrocks, 2010). These meetings were not found to be necessary during analysis, however – signalling the suitability and robustness of the coding framework.

The second stage of the analysis involved identifying the social and political practices, as well as the social, political and fantasmatic logics that underpinned them. Once the first stage of analysis was complete, two members of the research team (LK, KA) began identifying social and political practices contained within these shared ideas, beliefs, values, attitudes, and behaviours across the data set, along with their associated logics. A full description of these aspects, and how they can be identified is discussed above. During this stage, critical discussions about the coding continued amongst the research team, and team members reviewed others' analysis at regular intervals to ensure consistency and improve confirmability (Lodico et al., 2010).

### 2.3.4 Reflexivity

King and Horrocks acknowledge the process of reflexivity in qualitative research as a reaction “to the realisation that researchers and the methods they use are entangled in the political world.” (2010, p.126). As a result, researchers must recognise that their work will inevitably be influenced by political, social, economic or ideological motives, be transparent with readers about these, and reflect on the influence their own position may have on the research (Savin-Baden and Howell Major, 2013).

Throughout the study, from design to write-up, the research team met at regular intervals to critically discuss and challenge interpretations, to assess whether the conclusions drawn in the research accurately represented the perspectives of participants, or whether these might have been distorted by researcher input. This process is particularly important in research that deals with complex, contested and ideologically- or politically charged concepts, such as in this project, as it increases confirmability (King and Horrocks, 2010).

The diversity of the research team was a key strength during this process. Members had a wide range of educational and professional backgrounds, and a variety of expertise in areas such as psychology, Medicine and linguistic analysis. This diversity enabled a more critical questioning of interpretations, assumptions and power dynamics and heightened the opportunity for effective reflexivity.

## Chapter 3: Literature review and Problematisation

In the previous chapter, we outlined our theoretically informed research design, developed utilising the logics approach to critical explanation as our research ethos (Glynos & Howarth 2007). There, we outlined a specific purpose for this literature review: to assist with identifying the significant socio-political events that have impacted upon trust in professions, by altering perceptions of professionalism and approaches to regulation in Medicine and Law. This purpose is directly linked to our research objective to *critically explore* the historical socio-political events that have impacted on perceptions of professionalism and the role of regulation in relation to trust in Law and Medicine; so that we might understand the historicity of current ideas and beliefs about ‘trust’ and how it relates to ‘professionalism’ and ‘regulation’. We also use this chapter to assist with the second of our research objectives: to describe the attitudes, values and behaviours required of the modern professional to maintain trust in current socio-cultural contexts.

To achieve these purposes, in this literature review, we first establish what the current socio-cultural context is, before going on to explore what our three concepts (‘trust’, ‘professionalism’, and ‘regulation’) mean in this context. We then identify the specific significant socio-political events that have impacted on trust in professions within these contexts. We conclude this chapter with a comprehensive problematisation of the phenomena so far described.

### 3.1 Socio-cultural context

In order to describe the attitudes, values and behaviours required of modern professionals to maintain trust in their current socio-cultural context, it is first necessary to recognise what this socio-cultural context *is*. Social theorists attest that we live in a ‘neoliberal society’; that is, a society shaped and informed by the socio-political ideology of ‘neoliberalism’. Broadly speaking, ‘neoliberalism’ or ‘the neoliberal society’ refers to the third of three dominant socio-political ideologies that have existed in succession in modern, Western, capitalist societies. Ideologies that have shaped much of our social and economic policy (Gane 2013; Gane 2014; Davies 2010; Davies 2014a; Davies 2014b) as well as our ‘value systems’ (Boltanski & Chiapello 2005a and 2005b). Again, broadly speaking, these three dominant socio-political ideologies are: 1) classic liberalism 2) collectivism 3) neoliberalism. Each has evolved from the last and so ‘neoliberalism’ is defined both in terms of what it is now, as well as by what it is in relation to classic liberalism and collectivism. For that reason, all three ideologies shall be (briefly) summarised here.

#### 3.1.1 Classic liberalism

‘Classic liberalism’ refers to a political theory that developed and thrived in ‘the West’ during the eighteenth and nineteenth centuries (although then referred to as simply ‘liberalism’); and created the ideological space necessary for the introduction and sedimentation of capitalist processes. This is because ‘classic liberalism’ provided the political and moral justification for the implementation of capitalist economic policies, based on a shared idea that state intervention was detrimental to ‘progress’ – in both the economic and social sense of the term. Drawing substantially on the work of Adam Smith (1776) and John Stuart Mill (1859), classic liberal economic theory advocated that in a

non-interventionist state 'the market' and the individual or 'consumer' would interact in ways that formed a fair market capable of maximising the satisfaction of material needs and desires of society. Smith's (1776) idea of a non-interventionist state economically, corresponded with Mill's (1859) utilitarian, non-interventionist state politically. When combined, these works argued that 'non-intervention' as an approach to socio-economic policy was the path to both the most moral and just society, and the most fair and just economy.

The same time period is associated with the 'traditional' model of professionalism (Macdonald, 1995). Using Larson's (1977) concept of the 'professional project', whereby professions work to establish their status within society, Macdonald argued that Law and Medicine became established, respected and powerful professions. The success of their professional projects was based on securing a monopoly of expertise defining their area of work. The Rose Case in 1704 provides an illustration of the importance of protecting professional boundaries, where physicians fought a protracted legal battle to prevent apothecaries from encroaching on their domains of practice; prescribing Medicines. Controlling entry to the profession and access to the academic knowledge that informed practice were other important mechanisms used to secure the professional project. The introduction of university based, academic education enabled professions to control knowledge and exclude entry to sections of society with lower social status. Hargreaves (2000) argues that these processes enabled professions to practice independently, define their ethical codes, reifying their professional status. Furthermore, the emergence of entrepreneurship and patronage, as Law and Medicine became established professions, enabled them to meet the "twin goals of a market project and a status project" (Larson, cited in Burns (2014)), assuring their dominance and position in society.

The early 19<sup>th</sup> century saw the establishment of several professional organisations, which were expert groups with power, status and often monopolies on their fields of practice. They included the Inns of Court in England, the Law Society (from 1825) and the Royal medical colleges, which were under protective patronage.

In Medicine, new ideas about science and empirical study further strengthen the position of the profession (Macdonald 1995). As the professions became established, they were granted powers by the state to self-regulate, with considerable autonomy (Adams 2016). The Law Society was granted powers to regulate and discipline members in 1863 extending to whole of the profession in 1906 (Burrage 1996). The 1858 Medical Act formalised self-regulation of the medical profession through the establishment of the governing body, now known as the GMC (Dixon-Woods et al. 2011).

### 3.1.2 Collectivism

'Collectivism' refers to a notable policy turn towards state interventionism in modern Western societies in and around the 1950s. The dominance of classical liberal political economy began to decline at the beginning of the twentieth century following "the rise of corporations, trade unions, social policies, regulation and state socialism" (Davies 2014b, p311) and a growing concern with 'justice', 'fairness' and 'equality', over and above the mere generation of wealth. This decline was exacerbated by 'The Great Depression', where liberalism's unfettered capitalism was shown to be problematic and created a crisis environment in which society and policy makers alike were open to alternative suggestions as to how to 'do things'. This resulted in the socio-political acceptance of 'collectivist' interpretations and explanations of events. Indeed, in the aftermath of The Great

Depression, right through to the late 1970s, the work of collectivist theorist John Maynard Keynes (1883 - 1946) proved to be highly influential. His work advocated, and evidenced, that state intervention into the free market would mitigate against the detrimental effects of the 'boom and bust' cycles of capitalism that caused the unprecedented misery and suffering experienced in the aftermath of the Great Depression. In the UK context, this turn to collectivism made possible the founding of the welfare state – including the National Health Service (NHS) in 1948 and legal aid in 1949. A key characteristic of this socio-cultural context was that it was against an unregulated, 'free' market, due to the understood volatility of such a market and its evidenced potential to cause harm. However, the works of neoliberal theorists also being formulated at this time, were working to undermine and change this dominant socio-cultural context.

The traditional model of professionalism remained dominant during this period with the expertise of the professions being sought and trusted by the state to enact collectivist policies. The founding of the NHS was reliant on the involvement of doctors. In 1948, responsibility for implementing the Legal Aid Scheme was devolved to the legal profession (Macdonald 1995). The power and status of the professions ensured their involvement with the state in these policies and continued to support their professional projects, demonstrating the value of their roles in serving society. However, shifts to democratise professionalism in this period were evident as the state moved to require the professions to serve society, with some being employed directly by the state, in the case of doctors working in the NHS, as opposed to predominantly acting as private practitioners. Collectivism is exemplified by notions of "the energised, "good" doctor or other professional... constituted on a heroic template" (Burns 2014, p5).

Democratising trends continued to emerge with the state led introduction of lay members to regulatory boards by the 1960s followed by further mechanisms to involve wider members of society in the regulation of the professions in the 1990s (Adams 2016). Accountability to the public and wider stakeholders suggests a challenge to the traditional professional project - being held to account by those they serve could be interpreted as undermining professional autonomy - however, despite this move professions still enjoyed the permissions of self-regulation.

### 3.1.3 Neoliberalism

'Neoliberalism' is a dominant way of thinking about the world which is discursively produced, sedimented, and reified. This dominance was achieved through the successful problematisation and contestation of 'collectivism'. Drawing on classical liberalism's moral justification for capitalism, 'neoliberalism' attests that 'collectivism' erodes individual rights and democracy. The rise of collectivism, it is claimed, was deeply problematic as it was demonstrative of a return to fundamentally immoral and ideologically based (rather than evidence based) policy making. With that said, the emergence of 'neoliberalism' was not, and should not be understood as, simply a return to 'liberalism' from 'collectivism'. 'Neoliberalism' is comprised of a number of new characteristics that are distinct from classic liberalism (see: Gane 2013; Gane 2014; Davies 2010; Davies 2014a; Davies 2014b for further detail of neoliberalism's characteristics that are distinct from classic liberalism). Broadly speaking, Davies (2014b) characterises 'neoliberalism' as being composed of four key characteristics: firstly, that classical liberalism forms the inspiration rather than model for it. Secondly, that neoliberalism is concerned with the expansion of market principles into the social sphere of

everyday life. Thirdly, that competition and inequality are viewed positively in this ideology. And finally, that the state must be an active, supporting, force of neoliberalism in order for it to continue to enjoy socio-political hegemony.

Neoliberalist influences promoted a shift to a 'managerialist' approach to professionalism. Marketization, competition and the use of performance targets were deployed to manage services as well as the professions working within. Such moves have eroded the traditional professional project. Ball (2008) argues that neoliberal policies have significantly changed the nature of professional practice by "...reshaping the culture and structures of governance and of service relationships..." (p 62). Ball uses the concept of performativity to refer not only to the effect of performance management systems on the enactment of professional practice, but also on individual professionals' sense of autonomy and expertise.

Greater scrutiny of professional activity through new opportunities for increased surveillance has further enabled the growth of corporate management. Use of targets and measures of quality to justify and limit costs reduces the power of the professions to influence their practice (Martin et al. 2015). Additional measures to assure the public and stakeholders that professional standards are maintained, and professionals are accountable for their practice have been introduced. Revalidation within Medicine (Dixon-Wood et al. 2011) and the emergence of formal disciplinary structures within Law (Burrage 1996) exemplify the gradual erosion of the power of the professions to self-regulate and practice autonomously questioning the "...natural alignment between the interests of the profession on the one hand and the state and patients [or client] on the other hand." (Dixon-Wood et al. 2013, p.1457).

Public awareness of high-profile scandals of cases of malpractice in Medicine and Law have given credence to the introduction of formal, compulsory regulatory mechanisms (Hazgui et al. 2015; Burrage 1996). Archer et al (2013) argue that the impact of high-profile scandals has been a significant factor supporting the introduction of revalidation enabling poor performing doctors to be identified, and, if possible, remediated. Archer et al. (2013) also note the influence of marketization, rising systems pressures in the NHS and the loss of public trust in professional knowledge as contributory factors that paved the way for the introduction of revalidation.

The professions of Medicine and Law have therefore become increasingly accountable to formal mechanisms which control, define and evaluate their practice. Working within systems directed by neoliberal policies foregrounding marketization, competition and achieving targets, the influence of traditional and democratising models of professionalism have arguably given way to a managerial approach to professionalism: a performative notion of professionalism gaining dominance (Ball 2008).

### 3.1.4 Implications for this study

So what does this mean for this study? In recognising that everything explored in this study is done within a neoliberal socio-cultural context, our research objective essentially transforms slightly. We are actually going to (and only able to): describe the attitudes, values and behaviours of the modern professional required to maintain trust in *a neoliberal society*; to know what makes a 'neoliberal professional' trustworthy. To do so, we must begin with a clear understanding of what a 'neoliberal professional' is. This question is something that a number of theorists have begun to consider.



Mark Fisher (in Fisher & Gilbert (2013)) notes that the result of the shift in the dominant ideology of the government from 'collectivism' to 'neoliberalism' was a *state legitimised* process of 'neoliberalisation' of British society. That is to say, that the state accepted, not challenged, the incorporation of market principles into the social sphere of everyday life. The state accepted the silent uncoupling of 'the individual' from previous fundamental rights that collectivism had established (such as education and welfare); accepting instead the only alternative offered in their place - the right to buy services on the privatised service market. Such rights assumes the presence of empowered, informed consumers who are capable of rational choice, motivated by individual need; and subjugates professionals by positioning them as social actors providing services for consumption that can satisfy such consumer need. In this context, as Lorenz (2012) notes, even non-market activities such as the provision of education, health care, and legal aid are *commodified* so that they can be made 'efficient' and even profitable.

The application of market principles to the public sector and the professionals that work within it (via policy) is commonly known as New Public Management (NPM). NPM was developed in the US in the 1980s and was soon adopted by the UK. In essence, it is a term for the application of private sector management techniques and strategies to the public sector. Typically this takes the form of the introduction, and collation, of quantifiable 'performance measures' or the setting of 'performance targets' - for example, education league tables, or patient treatment quotas.

As Lorenz (2012) notes

*these (NPM) policies are characterized by a combination of free market rhetoric and intensive managerial control practices... NPM policies employ a discourse that parasitizes the everyday meanings of their concepts—efficiency, accountability, transparency, and (preferably excellent) quality—and simultaneously perverts all their original meanings (p600-601).*

Lorenz (2012) goes on to argue that NPM offers specific ideas about 'efficiency', 'accountability', 'transparency', and 'quality' and uses these to justify the existence of (and adherence to) NPM policies; highlighting that NPM is essentially the collation of arbitrary measures of performance (at both an individual and organisational level). Lorenz (2012) also suggests that all involved with complying with NPM know in some way these measures are arbitrary and not *really* measuring performance or making services better, but all are persuaded to comply because *not* complying has such severe personal and professional consequences. What is described here is essentially a process of 'neoliberalisation' of public professions through a process of 'neo-professionalisation' - that is, an ideological reconceptualization of 'professions' and 'professionals' to fit into the neoliberal ideological context. Here, 'neo-professionalisation' is achieved through the disempowerment of professionals and the subjugation of professions to market principles via the simultaneous process of: 1) increased accountability to management; and 2) undermining any ideas about 'efficiency', 'accountability', 'transparency', and 'quality' constructed by drawing on non-market logics. These policies are of course hugely significant to the medical profession which, although there are exceptions, is a predominantly public service in the UK – meaning that they have been, and continue to be, subjected to this turn to NPM. Indeed, some authors (e.g. Timmons, 2003; Waring, 2007 – cited in Martin et al. 2013, p80) have characterised what are, essentially, the management techniques of NPM, as a form of surveillance of professional practice in terms of Michel Foucault's (1979) notion of 'disciplinary power'. Here, the increased surveillance of NPM essentially works to open clinical practice to the gaze of managers in a

way that makes visible, and so regulates, individual professionals' conduct (Martin et al. 2013) – transforming healthcare professionals into 'good' neoliberal workers.

In the UK, the legal profession is a predominantly private service, although there are again exceptions; and so large sections are not subjected to the specific example of NPM. However, that does not make it resistant to the neoliberalisation of the profession. In recent history, the legal profession has moved markedly from a system that relied on long-term professional relationships to build trust, to a system of institutionalised trust. The routinisation and de-professionalisation of legal service delivery has acted to depersonalise the relationship between clients and their legal professionals, along with the expansion in the number of lawyers and inter-professional competition. Furthermore, populations are increasingly mobile and community ties are weakened by the advance of capitalism and the restructure and centralization of services (Webb & Nicolson 1999). As a result, informal controls on professional-to-client relationships, which in the past might have held substantial weight (as the relationship had to be maintained into the future), no longer possess so much influence (Webb & Nicolson 1999). Moreover, modern conditions are becoming increasingly hostile to a system that relies on trust in the status and altruistic motives of the profession (e.g. rise of consumerism, mass exposure of wrongdoing in the media, governmental antagonism). As a result, the public's faith in professionals is being eroded, they are becoming more sceptical about 'blindly' trusting professionals (Webb & Nicolson 1999) and are increasingly suspicious of lawyers, perceiving them to be untrustworthy and corrupt (Langford 2008). This context has seen an increase in the importance of regulatory and institutionalised forms of control, in part displacing traditional trust relations. In institutional systems of trust, "individuals commit to abstract systems, particularly those that codify and deliver expert knowledge" (Webb & Nicolson 1999). Trust relations are subsequently formalised through contractual and regulatory systems. Self-regulation has also become less voluntary and more mandated and structured (Webb & Nicolson 1999).

## 3.2 Trust, professionalism and regulation in the context of neoliberalism

### 3.2.1 Trust

Defining the term "trust" in neoliberal society is challenging. Nevertheless, it is something that we have attempted to do through an exploration of the relevant literature (and, later, in discussions with participants). As previously discussed, at the core of neoliberal ideology is classic liberalism's notion that the market system is the most fair and just way of structuring a society. If we return to the work of Adam Smith (1776) which, as we have already noted classic liberal economic theory drew heavily on, trust is positioned as something that is essential to this market system of supply/demand and laissez faire economics (Salerno 2018). This is because it is understood that without it, and without the 'trustworthiness' of service providers and consumers, the market would simply fail. This sentiment has clearly transitioned into neoliberal thought – for example, prominent neoliberal thinker Francis Fukuyama (1995) posits 'trust' as being essential to a healthy economy as it underpins business success and economic prosperity. Some have argued that neoliberal ideas of 'trust' have surpassed the notion that it is something essential to market system of supply/demand; positing it instead as a neoliberal commodity to be supplied and demanded (Arvanitakis 2009). So, what then does this mean for professionals who, as we have previously shown, are conceptualised as 'service providers' in the

neoliberal context? This is a question that we hope to explore in this chapter. Thinking more broadly (and perhaps less economically) ‘trust’ is often associated with familial, friendship or community relations, with shared (and often local) understandings, affiliations, cultures and values underpinning the intimacy and conventions within those trust relationships. Here, ‘trust’ is rooted in the personal knowledge of the other and their abilities (Webb & Nicolson 1999). ‘Trust’, it seems, is an essential to sustain a neoliberal society – specifically, the perceived ‘trustworthiness’ of both the service provider and consumer plays a clear role in its sustenance, but ‘trust’ also plays a role in sustaining other existing relationships and networks that structure the status quo. However, there is not the scope here to explore the role of ‘trust’ in all of these different kinds of neoliberal relationships. Our focus is to understand the development of a trust relationship between the specific relationship of a client/patient and a professional, and the public trust in the profession at large.

### 3.2.1.1 Trust and Law

We identified and reviewed a number of contemporary law policy documents dating from 2015 to 2019 to explore how the concept of ‘trust’ was articulated within these. The documents explored outline the principles that must be adhered to in professional legal practice - including maintaining honesty, integrity, transparency, and avoiding conflict of interest with the aim of maintaining public confidence and trust. The documents examined were the Legal Service Act (2017), Legal Standards Board Framework Document (2018), the Bar Standards Board Handbook (2019), the Solicitors Regulatory Authority Handbook version 21 (2018), and a document produced by the Solicitors Regulatory Authority (SRA) called “A Question of Trust” (2016).

The Legal Service Act (2017) contained no references to trust and the Legal Standards Board Framework Document (2018) contained one reference indicating that the Ministry of Justice and the Legal Standards Board should be based on an “open and honest, trust-based partnership” (2018 p3). The Bar Standards Board Handbook (BSBH) provides a code of conduct for barristers and is updated at least annually. Likewise, the Solicitors Regulatory Authority Handbook (SRAH), updated at least annually, gives solicitors and other legal professionals guidance around required ethical conduct. The regular updates to both of these handbooks are more technical in nature, with minor amendments to specific areas of practice. Definitions of trust in both documents are similar. The core duties/principles described in the BSBH (2019) and the SRAH (2018) refer to trust in the following ways, highlighting to registrants the vital importance of public trust:

*Core duty 5: You must not behave in a way which is likely to diminish the trust and confidence which the public places in you or in the profession (BSB 2019, p22)*

*Solicitor Regulatory Authority principle 6: Behave in a way that maintains the trust the public places in you and in the provision of legal services (SRA 2018)*

This idea of the vital importance of trust is reflected in the literature. ‘Trust’, it is understood, is partly built through a client’s feeling of security that their legal professional will act as expected and the way they promote (Brien 1998). This is particularly linked to the motivations and intentions of the person being trusted – the client must believe that their legal professional does not intend harm to them or their investments and interests (Brien 1998). The idea of ‘trust’ is thus also imbued with hopes and expectations for the future, a sense of mutual commitment, and is not necessarily rational (Webb &

Nicolson 1999). Here, we can see the effect of macro-level, neoliberal concern with ‘trust’ impacting at the meso level of professional practice. In an example of neo-professionalisation of the legal profession, the legal professional is held to the same standards as any other service provider – they must demonstrate their trustworthiness in order for the profession at large to be ‘trusted’.

### 3.2.1.1 Trust and Medicine

We identified and reviewed a number of contemporary and historical medical policy documents in order to explore how the concept of ‘trust’ was articulated within them. The General Medical Council (GMC) is the statutory body which regulates doctors. An important document that the GMC produces is ‘Good Medical Practice’ which offers guidance and sets standards for doctors on how they should act professionally; the most recent version of which was published in 2013 (GMC 2013). This has, over the past 20 years, placed increasing emphasis on the importance of obtaining and sustaining trust. The first iteration of Good Medical Practice (1995) has a section on maintaining trust which includes:

*the need to listen to patients... giving information to patients in a way they can understand ... (and)... respecting their rights to be fully involved in decisions about their care (p4)*

Suggesting that here ‘trust’ is desirable; that it is desirable for a doctor to be trusted by their patients (and offers mechanisms through which trust can be facilitated). By 2013, Good Medical Practice emphasises the implications of trust in the doctor/patient relationship noting

*Patients **must** be able to trust doctors with their lives and health (GMC 2013 p2, emphasis added).*

Here, ‘trust’ has transformed into a *necessity*; it is *necessary* for a doctor to be trusted by their patient.

Good Medical Practice (GMC 2013) then further develops associated concepts related to enabling doctors to enact trust; advising them to consider how they should relate to patients and colleagues, of the importance of maintaining the highest standard of clinical competency, and of enacting values such as honesty, trustworthiness and integrity (GMC 2013). Within this guidance, it is made clear that any failure to meet these standards (including failure to be trusted) has potentially serious repercussions for professionals. That the GMC has become increasingly interested in the concept of ‘trust’, defining it more clearly and emphasising its importance, is of great interest to this project. Here, again, we can see the effect of macro-level, neoliberal concern with trust impacting at the meso level of professional practice. Similarly to Law, as an example of neo-professionalisation the medical professional must demonstrate their trustworthiness by adherence to their professional standards.

More recently, it appears as though there is less of a policy concern with defining and establishing ‘trust’ between the medical professional (service provider) and patient (consumer). Indeed, Person’s (2017) independent review of medical revalidation noted the importance of trust as a basis for medical practice. Yet the review itself focused on the process of revalidation and the value of revalidation as a tool to improve learning and performance as a means by which to assure trust in the profession. Most recently, Hamilton (2019) in the review of Gross Medical Negligence, Manslaughter and Culpable

Homicide<sup>1</sup> argues that there is a significant need to rebuild the relationship between the medical profession and its regulator as a consequence of the medical professions' loss of confidence in them. Raising, for the first time that we have been able to identify, the issue (and importance) of trust between the regulator and the profession.

### 3.2.2 Regulation

In the previous section (3.2.1) we noted that some have argued that neoliberal ideas of 'trust' have surpassed the notion that it is something essential to market system of supply/demand; positing it instead as a neoliberal commodity to be supplied and demanded (Arvanitakis 2009). Arvanitakis (2009) goes on to argue that, if we accept that trust is a product, a commodity, something to be bought and sold, then there must also be some form of 'trust industry' responsible for its production, distribution, and – arguably – rationing of it in order to produce a scarcity of it and drive up its value. Furthermore, Salerno (2018) notes that in the neoliberal society, 'trust' is not just essential for a healthy economy, but a healthy society. 'Trust' (or rather a distinct, controlled lack of it) has a stabilising quality, positing it as an essential for maintaining the status quo. Stating that:

*social unity is often built upon enlightened mistrust.... It is certainly their own mistrust of the majority that holds the most powerful together. It typically is the most powerful and most affluent that distrust the potential power of those below them, especially those who they have exploited for their own well-being. (p35)*

When we apply these macro-level discussions about trust to the meso-level focus of our study, the ideas and arguments presented here offer a novel way of conceptualising professional regulation. Consider again the idea that the process of 'neo-professionalisation' (re)conceptualises medical and legal professionals to fit into the neoliberal ideological context; positing them as service providers, and their patients/clients as consumers. The ideas presented here suggest that the market systems to which these neo-professionals are associated (Medicine and Law) are not just reliant on the existence of 'trust' between service provider and consumer; they are associated in some way with a 'trust industry' – individuals or organisations that are *producers* and *distributors* of 'trust' in their profession – that awards trust.

Both the legal and medical regulators describe their roles (on their websites) as being to:

*...make sure that individuals and firms that we regulate operate independently and with integrity in the interests of their clients and in the wider public interest...[and]... supervise firms and individuals who are regulated by us, and ...take enforcement action against those caught breaching our Principles... [and] also make sure that those we regulate are qualified and insured to provide legal services (SRA)*

*...set the education and training requirements for becoming a barrister...[and] setting continuing training requirements to ensure that barristers' skills are maintained throughout their careers ... [and] monitoring the service provided by barristers and the organisations we*

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<sup>1</sup> an independent review commissioned by the medical regulator as a result of significant national debate challenging the GMC's decision to seek erasure of Dr Bawa Gaba from the medical register following the death of a child under her care

*authorise to assure quality... [and] protecting and promoting the public interest...[and] the interests of consumers (BSB)*

*...protect patients and improve medical education and practice across the UK (GMC)*

And so it is reasonable to assume that these regulatory bodies act as some kind of trust producer and distributor. In the sense that they act as gatekeepers to the professions (and professionals) that they regulate; determining their trustworthiness and ability to interact with 'the public'. Furthermore, if we conceptualise regulatory bodies as 'the most powerful'<sup>2</sup> in the relationship between themselves and their associated profession, and unified (in terms of power) with 'the public'<sup>3</sup>, Salerno's (2018) observation that it is a mistrust of the majority that holds the most powerful together becomes incredibly interesting. It seems to necessitate a shared regulatory and consumer *mistrust* in the professions in order to maintain the status quo of hierarchy that subjugates, and makes accountable, professionals to both the regulator and the public.

### 3.2.2.1 Regulation and Law

The organization of the legal profession has developed with the aim to reassure both the public and the courts that legal professionals are competent to undertake their role and work, to fulfil the expectations of acting clients' and public interest (Montgomery 2007) and to control for cartelism and malpractice (Boon 2010). The regulatory process of certification is believed to assure potential clients that legal professionals have proven themselves minimally competent and to be of suitable character to be worthy the necessarily or reasonable level of 'trust' required to practice (Langford 2008). Moreover, checks (character and fitness requirements, as well as on competency to practice) are precautionary measures to protect potential clients from substandard practitioners as well as to maintain the belief in the 'professionalism of the Law'. It seems as though there is a belief that, without screening and setting base standards, the profession cannot claim to be proactively protecting public interest or upholding the standards of the profession, but rather waiting for malpractice to emerge at the detriment of clients and the profession (Langford 2008).

In 2015 the Solicitors Regulatory Authority initiated a consultation called *A Question of Trust* exploring what needs to happen when professional standards are not adhered to. As the name might suggest, it sought to explore, in more detail, the notion of 'trust'; including questioning the public/private aspect of being a professional (a point that we return to in section 3.2.3.1). It reports that some Legal roles may require 'additional trust', and that senior Legal professionals are in some way more trustworthy. The consultation questioned the boundaries of professional behaviour, and emphasised the need for consistent standards and responses by the regulator to professional transgressions – positing consistent regulation as a mechanism for gaining trust in the profession/professionals.

In this document, ideas of financial gain and vulnerable clients complicating the 'trustworthiness' of the profession are also introduced. Such ideas are mirrored within the supposed causal factors for

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<sup>2</sup> A position defensible by the notion that as the professional regulator, if a professional's 'fitness to practice' is found to be lacking, they are empowered to restrict their practice or remove them from the professional register (thus preventing them from practicing again).

<sup>3</sup> A position defensible by the notion that professional regulators act on the public's behalf and so must understand their wants and needs, and have been granted power by them whilst still remaining accountable to them.

losing trust reported by the Bar Standards Board, who state that a professional will lose trust because they have misused their position to obtain pecuniary advantage; or misused their position of trust in relation to vulnerable people. Situations in which legal advice is required are often those in which clients are vulnerable because they are in a high-risk situation (e.g. accused of a crime, caused an accident, face financial loss) or have an investment that is at risk (e.g. buying a house, supporting a business venture). This vulnerability, it seems, is itself integral to the creation and maintenance of 'trust'. As clients lack the expert knowledge of legal issues and processes, they must delegate the management of valuable assets, sensitive information, and key responsibilities to their legal professionals in order to create successes (e.g. wealth, positive outcomes) (Arnold & Kay 1995; Daly 1999; Montgomery 2007). Engaging the service of a legal practitioner may thus be seen as a way to mitigate and manage the level of risk within a situation where a client has something at stake but lacks the required legal knowledge to protect these interests himself.

However, entering in to a trust relationship with a legal practitioner itself creates a new type of risk, as the client now must rely upon this practitioner to act in their interests and not further damage them or their situation (Webb & Nicolson 1999). Moreover, as clients lack the expertise and opportunity to judge the quality or supervise the work of legal professionals, there exists a large asymmetry and power imbalance in the relationship. This asymmetry creates and institutionalises possibilities for trust violation, as it permits clients to unquestioningly accept their lawyer's judgements and increases the opportunity for opportunistic malpractice (Arnold & Kay 1995). Something that is noted in the SRA's (2015) consultation document, which states that the specialised knowledge held by professionals means their relationship with those seeking their services will usually be unequal and so clients must be able to trust their legal advisers. Trust, and ensuring this is well-placed, thus becomes essential for the functioning of the professional relationship and the service, and for the client not to erect barriers to protect interests or withdraw from the relationship. To trust a legal profession thus requires clients to accept a risk of abuse when already vulnerable (Brien 1998; Webb & Nicolson 1999). This threat has also led the profession to take steps to ensure client and public trust remains a cornerstone of professional behaviour, employing both internal and external regulatory systems to help control and demonstrate this.

Here, 'professional regulation' is posited as a mechanism for reducing the risk associated with trusting a legal professional. It is apparent that interwoven into this justification for, and apparent purpose of, the regulation of the legal profession is the idea that trusting a professional makes an individual vulnerable. It subjugates the individual to the profession because they lack the specialist knowledge required to protect their own knowledge. Regulation offers the individual respite from having to identify a 'trustworthy' professional to place their 'trust' in; as it ensures that all professionals are 'trustworthy'. However, in doing so, it subjugates the individual to the regulator instead. Immediately we can see that these regulatory bodies act as both 'trust' producer and distributor; they determine the presence and levels of 'trustworthiness' in the profession and they distribute it to professionals, maximising public 'trust' in the profession and, at the same time, in the regulators themselves.

However, for external regulation to be successful in the eyes of the public, the regulatory authority itself must be perceived as credible to give clients knowledge by induction that the service provider has been credibly assessed by a credible body (Webb & Nicolson 1999). As the public is again in a position where they are unlikely to be able to judge whether or not the institutional systems are reliable and trustworthy, they must rely on the institution's reputation and status. Within the

profession, maintaining trust in the regulator is also important but often problematic, especially when practitioners perceive that regulation is not flexible enough to allow practitioners to deal with the complexity, segmentation and ambiguity of their profession (Boon 2010). Systems of accountability and audit can increase a feeling of unnecessary 'surveillance' and reduce the time practitioners spend with clients (Evetts 2009). Boon (2010) argues that treating lawyers as untrustworthy risks lessening their collective sense of responsibility for their own high ethical standards, and in encouraging or enforcing others to do the same. Moreover, it might make them more resistant to reform and change (Boon 2010). Finally, if the regulator is not perceived by the profession as well enough informed or ineffective, it can also lead to a breakdown of trust in the relationship between this and the rest of the profession (Boon 2010).

### 3.2.2.2 Regulation and Medicine

In section 3.2.1.2 we noted that there has been an increased concern with establishing 'trust' in medical professionals within regulatory materials. However, it is not just within medical regulatory materials that this turn towards 'trust' is noted. It can also be seen from a broader health care policy perspective. For example, whilst the Medical Act (1983) and its subsequent amendments make no reference to trust, from 2001 onwards the importance of trust as a central tenant of medical professionalism is clearly articulated in the context of seeking to assure the patients and the public that doctors are fit to practice. By 2006, Sir Liam Donaldson argued in 'Good Doctors, Safer Patients', a report proposing the introduction of medical revalidation, that the outcome of such regulatory processes needs to ensure the trust of patients and the public, as well as other interested parties (including employers and the medical profession itself). Achieved by assuring them that doctors are competent to provide patient care (DoH 2006). Donaldson's argument begins to articulate the move from a traditional self-regulated professional model to one where mechanisms to hold the profession to account lie outside to the profession itself. But also articulate a change in the idea of what 'trust' is. Here, there is very much a sense that 'trust' in the profession can only be derived from *knowing* that they are competent, resenting a notion of 'evidence-based trust' – which, arguably, is a contradiction of the very idea of 'trust'. We see this contradiction around the idea of 'trust' resolve its self and the argument develop more clearly in the Secretary of State for Health's white paper 'Trust Assurance and Safety' (DoH 2007). It sets out the need to introduce revalidation systems for health professions based on the rationale that self-regulation was not sufficient to assure patients and the public alike of the fitness to practice of practitioners caring for them (DoH 2007). Here, 'trust' emerges as something that can be awarded once professional competency has been established. The document comments on the continued trust that the public have in medical professionals but observes that the profession

*has moved on...from a position where trust alone was sufficient guarantee of fitness to practise, to one where that trust needs to be underpinned by objective assurance (p.32)*

Indeed, our review of policy documents related to the regulation of the medical profession, highlights a significant shift in ideas about the role of regulation - moving from a traditional, self-regulated conception of regulation, to one that is subject to much greater external scrutiny through formal regulation systems and mechanisms. The most notable shift being one that we have already alluded to - the introduction of 'revalidation' of the profession.



Here, we see similar ideas emerging to those discussed for the Law profession in the previous section (3.2.2.1). However, what we are seeing in the context of medical regulation that we don't in legal regulation, is *a specific idea of how* regulators can offer the individual respite from having to identify a 'trustworthy' professional to place their 'trust' in; *of how* they can ensure that all professionals are 'trustworthy'. This being to test and 'revalidate' professional competency. Here, not only is the regulatory body acting as both 'trust' producer and distributor; they are doing so in a way that makes their own processes for doing so, transparent and subject to public scrutiny – arguably demonstrating their own 'trustworthiness'. This is a distinct difference between the medical regulator and the legal regulators.

Indeed, the ability to publicly scrutinise the *regulator* as well as the profession is a concern that only appears to be growing. The complexity of this is articulated by Hamilton (2019), where a distinct loss of public and professional confidence in the medical regulator is described and the cause explored. The cause of this loss of confidence, it seems, is associated not only with the GMC's response to the Bawa-Garba case, but also a sense that they were subsequently not willing (and continue to be unwilling) to acknowledge the causal relationship between the clinical workplace clinical errors. The review also highlights that, despite this challenge to confidence in the regulator, there remains a continued high level of public trust in the medical profession.

### 3.2.3 Professionalism

Just as defining the term "trust" in neoliberal society is challenging, so too is defining the term "professionalism". In our exploration of literature relating to 'professionalism' we have identified that expert professional elites play a vital role in sustaining the structure of power relations through which neoliberalisation has been made possible - what Brown (2015) refers to as a 'stealth revolution from above'. Under the structural and political pressures of neoliberalisation, the expert division of labour in Western political economies has, Brown (2015) attests, fragmented professional expert groups; transforming them into intense, polarised organisations involved in ongoing power struggles. Indeed, this fracturing and polarisation of professional organisations marginalises the collective interests and values of professionals, undermining the coherence and relevance of established professional authority and status (Freidson 2001). Making it possible to (in very basic terms) transform 'the professional' into 'the worker' by capturing and controlling (with neoliberal logics), 'professions' in order to secure the economic, political, and cultural rewards which flows from them. We posit that a mechanism to achieve this, is to capture and control the very idea of what 'professionalism' is.

Larson (1990; 2013) outlines the characteristics of professionalisation projects typically mobilised by expert groups seeking to carve out and close off areas of specialist work, which can provide social and market stability and advantages. These are:

- 1) the construction and protection of a cognitive/knowledge base
- 2) a legitimation strategy focused around control over this cognitive/knowledge base (e.g. professional register)
- 3) an organisational strategy through which experts attain the ability to secure the protections and privileges which professionalisation bestows (e.g. self-regulation)

Thus professionalisation is, for Larson (1990; 2013), a (state-legitimised) process by which producers of specialist services strive to constitute and control a market for their expertise (Reed 2018). It is clear that both Medicine and Law meet the criteria here to be conceptualised as ‘professions’. However, what is of interest here is not whether these professions are actually ‘professions’; but rather, what ‘professionalism’ means to these ‘professions’ and what (if any) impact ‘neoliberalism’ has on conceptions of medical and legal ‘professionalism’. This is an important point to explore because, as Friedson (1994; 2001) attests, in a neoliberal socio-cultural context, ‘professionals’ will be transformed into mere ‘technical experts’. This subjugates ‘professionals’ to ‘neoliberal elites’ in a variety of ways. These ‘neoliberal elites’ are a comparatively new group of professionals who provide a particular set of specialist knowledge, skills, and technologies which mediate, absorb, and contain challenges to the neoliberal state (Reed 2018). They manage new ‘competitive’, ‘audit’, and ‘accountability’ regimes imposed on professions via the neoliberal state and, as Davies (2017) suggests, they constitute an emergent ‘consultocracy’ who perform intermediary and translation roles – translating the ‘neoliberal’ into the ‘professional’. An example of which, we argue, would constitute the conceptualisation and definition of ‘professionalism’ into a neoliberal context, and presentation and imposition of these ideas, *onto* a profession. Thus identifying whether this has taken place, how it has or has not, and who has played a crucial role in implementing or defending against such processes of neoliberalisation is of great interest to this project.

### 3.2.3.1 Professionalism and Law

From everything explored thus far in relation to ‘trust’ and the legal profession, it can be argued that the public places trust in those providing legal services due to a combination of necessity and expectation in the ‘trustworthiness’ of the profession. However, although clients may initially be forced to trust their legal professionals, this trust, it is argued in the literature, is influenced by their experiences, and the experiences of others, during a testing of this trust (Brien 1998). Despite initial trust bestowed on them, professionals must nonetheless behave in a way that maintains public and client trust (Boon 2010). Indeed, a significant focus within legal policy documents appears to be placed on the behaviour of legal professionals both within the context of work (including association with other legal professionals who are in good standing as well as outward facing activities like the advertising of legal services) but also in the context of their personal lives. For example, it is recommended that legal professionals dissociate from acquaintances that could bring either the registrant or the profession into disrepute:

*Members of the public should be able to place their trust in you. Any behaviour either within or outside your professional practice which undermines this trust damages not only you, but also the ability of the legal profession as a whole to serve society (SRAH 2018)*

*...merely by being associated with such person, you may reasonably be considered as bringing the profession into disrepute or otherwise diminishing the trust that the public places in you and your profession... (BSBH 2019) and;*

*Any behaviour either within or outside your professional practice which undermines this trust damages not only you, but also the ability of the legal profession as a whole to serve society. (BSBH 2019)*

Such recommendations are reified in the SRA's consultation document (2015) which, amongst other things, sought to explore and question the public/private aspect of being a professional. It concluded that:

*Every person has their own value set and makes their decisions accordingly. For example, for some people, things that happen in a solicitor's private life are not relevant to their role as a lawyer. Conversely, others think that bad behaviour outside the workplace undermines public confidence in the profession.... For us, this presents two issues. One is that the decisions we make will seem wrong to many people, and the second is that we must ensure that our own decision-making is consistent and in line with a validated regulatory position (SRA 2015, p5)*

Indeed, The Law Society argued that if complaints arising from unwanted behaviours in the personal life of a legal professional, for example dishonesty, are not addressed by the regulator, this would undermine public trust. The view that appears to be constructed in these codes of conduct is that the behaviour of a legal professional in their personal lives is of equal importance as their professional behaviour. Furthermore, that the individual's personal and professional behaviour is demonstrative of their 'professionalism'. The idea of 'legal professionalism' then, clearly transcends the personal/professional boundary; but what does this mean? What personal and professional behaviours denote 'legal professionalism'?

Such behaviours denoting 'professionalism', according to the literature, include honesty and transparency. Indeed, Brien (1998) attests that in a trusting professional relationship, there will be a 'trust' that the professional will honestly perform their role in the interests of their client, and that the client will honestly provide the information the professional requires to do this. 'Trust' is thought to be built faster if there is transparency between the parties with regards to their circumstances, motives and actions, and if these compare favourably to expectations (Brien 1998). In this way, professional relationships and networks generate 'trust' through establishing expectations of, and enforcing norms for future, 'professional behaviours' (Arnold & Kay 1995). Furthermore, Legal professions operate within a marketplace and the importance of relationships within this market is recognised as a key way for professionals to maintain and build business when selling complex products. A market such as this, with relationships at the core, stresses the importance of the reputation of firms and practitioners; and 'trust' is developed here through direct or indirect experience of 'professionalism' (Hanlon 2004; Ogus 1995). When the client is vulnerable, 'trust' in a professional's 'professionalism' provides feelings of security and lessens uncertainty about the behaviour of the practitioner, including a trust in their confidentiality over the information they hold (Daly 1999; Evetts 2009). Such 'trust' in 'professionalism' reassures that although clients are vulnerable, practitioners will not take advantage of them and will act in their interests (Brien 1998).

'Professionalism' here then, is a set of demonstrable behaviours that foster strong relationships and enable 'trust' to manifest. Indeed, 'trust' awarded in response to good performance, altruistic behaviour and the fulfilment of expectations can thus bring advantages and access to markets. However, within a framework underpinned by high expectations of ethical behaviour, even one unethical action on either side (client or practitioner) can diminish or break this 'trust' (Brien 1998). If trust is lost, the firm or individual risks the threat of formal (regulatory) sanctions, or informal sanctions by the loss of a good reputation and client network (Hanlon 2004; Webb & Nicolson 1999). Indeed, within the professions, including the legal profession, it is expected that practitioners' self-interest is put secondary to the interests of their client and the public good (Montgomery 2007). In

addition to this attitude of ‘public altruism’ (or ‘civic trusteeship’), it is expected that legal professionals are highly competent in the knowledge and skills necessary for professional work and that they respect for the justice system and its participants (Montgomery 2007).

Broadly speaking, legal professionals’ themselves appear to have control over defining what demonstrable behaviours denote ‘professionalism’. However, it is important to note that this is seemingly only possible as both regulatory bodies adopt the stance that ‘professionalism’ is a subjective concept – that *‘every person has their own value set and makes their decisions accordingly’* (SRA 2015, p5). The issue of having to definitively define or categorise a behaviour as ‘professional’ or not seemingly only arises when ‘professionalism’ is called into question in some way.

### 3.2.3.2 Professionalism and Medicine

Again, from everything explored thus far in relation to ‘trust’ and the medical profession, it can be argued that the public places trust in those providing healthcare services due to a combination of necessity and expectation in the ‘trustworthiness’ of the profession. However, ‘medical professionalism’ is an ambiguous and contentious concept and, despite intense academic research with international conferences, systematic reviews, policy working groups and reports, and regulatory guidance devoted to it, there remains little consensus on what ‘medical professionalism’ actually is. Such ambiguity could be due to there being a number of challenges that one faces when tasked with defining what is meant by ‘medical professionalism’ – such as the changing expectations of patients and regulators in relation to medical professionals’ behaviour. Indeed many of the original tenets on which the profession was historically built, and which defined ‘medical professionalism’ in some way (for example, self-regulation and professional autonomy) have changed in recent years (Allsop 2006; Cruess & Cruess, 2009).

This ambiguity surrounding this terms an in important and significant point to note, as if a doctor’s ‘professionalism’ is found to be lacking, the GMC is able to restrict their practice or remove them from the medical register altogether. Thus any confusion about what behaviour denotes ‘professionalism’ and what does not, can have serious repercussions for medical professionals. Therefore, any documentation or guidance that the GMC produces relating to professionalism, is important to help understand what ‘medical professionalism’ is. Particularly any document that may set, or outline, professional standards or standards of ‘professionalism’ for doctors to adhere to. As we have already noted, the primary document that the GMC produces to offer guidance and set standards for doctors on how they should act professionally is known as Good Medical Practice, the most recent version of which was published in 2013 (GMC, 2013). However, ‘professionalism’ is not explicitly defined in this document. Indeed, in echoing what was stated in the literature, ‘medical professionalism’ emerges as a blurry concept. The document implies the existence of a definition of ‘medical professionalism’ by outlining mandatory and desirable ‘professional’ characteristics, such as: to be knowledgeable, safe, trusted and to communicate well; as well as mandatory and desirable ‘professional’ behaviours. As with ‘legal professionalism’, behaviours denoting ‘medical professionalism’ include honesty and transparency; but *unlike* ‘legal professionalism’, behaviours denoting ‘medical professionalism’ also includes ‘being a good professional’ – a very subjective term delivered in this document in a very definitive tone. Indeed, unlike ‘legal professionals’, ‘medical professionals’ do not appear to have control over defining what demonstrable behaviours denote ‘professionalism’. The issue of having to

definitively define or categorise a behaviour as 'professional' or not has seemingly arisen *before* a professional's 'professionalism' is called into question in some way; and such ideas can actually be used to call a professional's 'professionalism' into question.

'Professionalism' then, is a set of demonstrable behaviours; the presence or lack of which, is determined by the regulator rather than other professionals or the public. This seemingly subjugates the professional to the regulator. In the sense that whether or not professionals know what 'medical professionalism' is, is irrespective of the fact that they must adhere to the behaviours thought to demonstrate it by their regulator. Professionals must behave in certain ways, irrespective of whether they understand why they must (beyond the understanding that if they do not, they face negative repercussions). This is not a new idea - Martin et al. (2012) suggest that the reinvigoration of 'professionalism' in Medicine acts as a mode of social control. Indeed, arguably, this ever-evolving set of regulatory expectations of the profession is the result of the gradual 'neoliberalisation' of the profession made possible by a number of high-profile 'scandals' (that we discuss in more detail in section 3.3). If we consider again the idea of neoliberalisation of a profession being to subjugate professionals to 'neoliberal elites', the subjugation of the medical profession to its regulator via the ambiguous notion of 'medical professionalism' becomes an interesting one. The question of whether the regulatory body constitutes a 'neoliberal elite' *translating* a neoliberal conceptualisation of 'professionalism' to the profession is something to be explored further with the relevant social actors.

### 3.3 High profile events

We have previously outlined a specific purpose for this literature review: to assist with identifying the significant socio-political events that have impacted upon trust in professions by altering perceptions of professionalism and approaches to regulation in Medicine and Law. So far we have identified the significance of the neoliberal context for current views on trust in professions, definitions of professionalism, and regulation of professionals. The next step in our literature review was to identify events that impacted upon 'trust' in professions. However, a challenge that we have encountered has been determining what events were significant and to definitively state their impact upon 'trust' in professions through the literature review alone. This is because an in-depth description of the impact of each individually listed event on the conceptualisation of trust in professions is lacking. This also means that it remains unclear whether and how values, attitudes, and behaviours that are required from professionals have shifted as a result of these events. Therefore, it is of key importance to address the impact of significant events within the interviews with social actors (Chapter 4). Thus, in this section we simply report any significant events that potentially have impacted the medical and legal professions. We will then be able to further investigate the actual impact of these events during the interviews with social actors (Chapter 4).

#### 3.3.1 Law

From recent public enquiries and reports (1948 – present day) we have identified two possible events that require more interrogation (Table 4, p.91 – reports signalling potentially relevant events have been indicated in bold). The first is the May inquiry in which Sir John Douglas May investigated miscarriages of justice related to the Maguire Seven and IRA bombing offences. The purpose of this inquiry was to examine the English system of criminal justice and to recommend changes to realise a

more efficient and effective system. The second is the Bloody Sunday inquiry which resulted from accusations of whitewash by family members of those killed or injured on Bloody Sunday. The lawyer that represented the soldiers during the inquiry claimed afterwards that the inquiry was one-sided and did not truthfully reflect the events that happened. We will discuss these and the other high profile events with social actors during data collection to gain a better understanding of the impact of these events on the legal profession.

### 3.3.2 Medicine

Please see Table 3 (p.90) for the high profile events that we have identified as having potentially impacted on 'trust', 'professionalism' and 'regulation' in Medicine. Although the exact impact of these events is unclear at this point, we speculate that: quality of care and patient safety have become prominent concerns in the delivery of healthcare following the publication of high-profile reports highlighting how sub-optimal clinical practice results in poor outcomes, wasted resources and harm to patients (Wachter, 2010). However, high-profile scandals involving egregious failings of individual healthcare providers (e.g. Mid Staffordshire Foundation Trust Public Inquiry, 2013) persist despite increased awareness of these issues (Martin et al. 2013). This persistence appears to have led to the implementation of the 'revalidation' process for all UK doctors in 2013 (Pearson 2017; annex c). We have also noted that The Hamilton review (2019) acts as a significant event as it raises, for the first time that we have been able to identify, the issue (and importance) of trust between the regulator and the profession.

### 3.4 Problematisation

In exploring the relevant policy documents and academic literature, we have drawn attention to the possibility that ideas about 'trust' and 'professionalism' contribute to the neo-professionalisation of both the medical and legal professions. In Medicine, 'trust' emerges as the product of, or something awarded because of, *demonstrable* professionalism. This particular type of 'professionalism' is discovered or uncovered by 'effective regulation' (by which we mean something that is both defined and performed by medical regulators). It is this specific manner of defining 'professionalism', and creating it as a discursive object that is controlled and defined by regulators and largely unknown or vaguely known by medical professionals, that leads us to suggest that medical regulators perform the role of 'neoliberal elites' – signalling the subjugation of medical professionals to the regulator and, in doing so, completing the neo-professionalisation of the medical profession. Conversely in Law, 'trust' emerges as the product of relationships whereby 'professionalism' is experienced or witnessed; and which is enhanced by regulation – in the sense that 'regulation' in Law ensures that all can assume that legal professionals are 'trustworthy'. Here, the legal profession are not subjugated to their regulators. Instead, the regulatory body seemingly works alongside them; they are partners in establishing professional trust.

We find this discrepancy interesting as, when we consider that each are professions operating within a neoliberal context, and so are subject to neoliberal ideas and values about the world, one might assume there to be consistency in terms of both how the terms 'trust', 'professionalism' and 'regulation' are understood and related. That each profession's ideas and beliefs about these concepts seemingly contradicts the other in terms of the attitudes, values, and behaviours of the modern

professional required to maintain trust is incredibly interesting and so it is necessary to understand how such a contradiction is possible. How can it be possible that there are (at least) two competing ideas about these concepts and how they relate together, and that the contingency of the neoliberal 'reality' is not challenged, questioned, or at least revealed? A problem that we explore in the next chapter.

## Chapter 4: Results

In this chapter we present the findings from our interviews with the relevant social actors identified (see Table 1, p.89). We interviewed 30 participants related to the two professions, representing a range of roles relevant to this project (see Table 2, p.89). We conducted a total of 25 telephone interviews, and 5 face to face interviews.

To answer our research questions, we focussed analysis on exploring participants' conceptualisations of public trust in the profession and in individual professionals. We explored how these conceptualisations impacted participants' perceptions of professionalism and their understandings of regulation. Finally, we considered how these conceptualisations of trust impacted their professional behaviour. Throughout, we paid particular attention to the socio-political events that might have influenced these perceptions.

This chapter is structured by the 'logics' approach. First, we present the social, political and fantasmatic logics that were implied by, and embedded within, participants' accounts. These logics explain how the practices we later identify were sustained, justified and reinforced; how practice comes to be. We then present two key social practices which emerged most strongly from the data. Participants identified these social practices as key to their roles as professionals in a neoliberal society. Together this analysis aims to draw out the taken-for-granted ideas and beliefs about trust, professionalism and regulation in Law and Medicine and exposes these to critique.

When little difference was found between the ways of thinking of those in Medicine and Law, the results are presented together. However, when analysis revealed substantial differences between the professions, these are reported separately to aid comparison.

To maintain the anonymity of participants, quotes are labelled with the participant ID number, the profession in which they currently work and the 'type' of role they undertook (e.g. P26, Medicine, policy maker). Definitions of these roles can be found in Table 1 (p.89). Some participants had experience working closely with members of the other profession, or experience in the other profession themselves (e.g. a legal professional who defended medical professionals; a medical trainee who was previously a Law trainee). In these cases, the participants are identified to the profession in which they currently work, although they may be referring to experiences in or with the other profession.

### 4.1 Social logics - the 'rules' underpinning 'reality'

In this section, we explore the social logics identified within participants' accounts. As discussed in Chapter 2, social logics "enable us to characterise practices in a particular social domain" (Glynos & Howarth 2007, p133) and therefore constitute the 'common sense' or normative conceptualisations underpinning and defining that 'reality'. In other words, these are the unspoken 'rules' that are implied in social practices, the beliefs and understandings which help explain why social actors act as they do. When these logics are identified and deconstructed, they enable us to describe and characterise 'reality', and to understand how it is maintained in this form.



#### 4.1.1 The importance of 'trust' and being 'trusted'

Our participants saw the practice of 'service provision' as a strong characteristic of their profession, and of their actions as professionals. Within this, participants felt that 'trust' was essential prerequisite for professional service. This was underpinned by a belief that trust is central to establishing a specific relationship between professionals and their patient/client, to enable a service to be properly and effectively provided:

*Okay so those that I'm representing, I think it's really important than I'm trusted – because otherwise you don't have that positive working relationship. And one of the reasons why I would be able to walk away from a case is if I felt that there wasn't the trust and confidence that the client is entitled to have in me. So yes it's really, really important that I'm trusted (P22, Law, policy acted on)*

*In my profession what I think of trust is, as I said, that another individual is able to give to you some of their deepest, you know allow you to see their vulnerability... and to expose their vulnerability to you knowing that you will not, that they will not come to harm as a result, so that is what I think is the key to trust with patients, I think (P15, Medicine, policy acted on)*

The perception of trust between professional and client/patient is thus understood to affect behavioural choices in this relationship - for example, whether a working relationship is entered into and/or maintained, or whether personal, sensitive information necessary for appropriate treatment is shared.

Moreover, the provision of effective service was fundamentally reliant on trust and positioned as crucial in contributing substantially to the satisfaction of the service user, and thus also the service provider:

*Yes so I have clients who say even if the outcome isn't what we hoped for, they always say before the result sometimes, before the verdict if I'm doing a criminal case - if they say to me no matter what, you did your best – that's displaying a really high level of trust in the fact that I did my best. And for me that is the highest accolade. Not that we won, because sometimes the outcome is outside our control or it's a little bit of luck, or you know, the evidence was always in our favour, so you know any damn fool could have run the case and won it, but the fact that they feel that you were on their side in the trench fighting the battle and that you were giving them courage (P21, Law, policy acted on)*

#### 4.1.2 The measurable nature of 'trustworthiness'

Underpinning the acceptance that professionals must demonstrate professionalism to patients/clients in order to be 'trusted', is a social logic that an individual's 'trustworthiness' and 'professionalism' can be measured, assessed and 'known' by others:

*Well I think you would want that [trust] in your relationship with professionals, and I think having sat on both sides of the fence if you like, I think you look for it and you look to try and find ways of showing that you're worthy of that, if you like, that belief from people. If you like as a consumer or an ordinary person dealing with a professional you're looking more initially*

*at whether they know what they're doing and are behaving appropriately – whatever that might mean (P11, Law, policy acted on)*

*So it's [trust] an assessment, it's something that's - there's like a balance that's tipped, once you have assessed - does this person mean me well, is this a good person and do they know what they're doing? And the data on which you would be making that assessment would not necessarily be something that you're consciously processing or consciously putting in the balance, it could be through signalling from the environment that you're in (P26, Medicine, policy maker)*

Participants reported that the first, and most important, step to demonstrating 'trustworthiness' was to demonstrate competence:

*Well I mean I think [to demonstrate and build trust] you show, you show that you have experience of these issues in the past that you kind of - I mean not that I would give them a long spiel about cases that I'd done before or anything like that - but more that when you're explaining the process (P12, Law, policy acted on)*

*What would make me particularly question a particular doctor was that if you got advice that [was] subsequently proved to be wrong. Now I do think some doctors get unnecessarily criticised for being wrong, simply because you can't be right all the time, particularly with a biological system – it often isn't easy to get the right identification of a problem. But if one practitioner gets it wrong more often than you feel they should do, you tend to think they're not quite up to the mark (P25, Law, policy acted on behalf of)*

Trustworthiness also became 'known' through the demonstration of certain (often subjective) professional qualities during one-to-one interactions between professional and patient/client:

*I think there's trust on a one to one basis – I trust this doctor in front of me because I'm his patient and I'm dealing with him or her about something now, we are at a meeting, we're face to face. So the first idea of trust for me is: I trust that the person I'm working with is working to some professional etiquette... And that professional etiquette would be around: I trust that they're going to respect me, I will respect them. Trust to me would be knowing that they're confidential. And also trust to me would be ... I would trust that if I challenged them that they would behave in a professional way, which means they could take the challenge and not push back in a negative or immature way... I expect and trust that their professionalism will mean they can talk ... to me and we can talk as mature adults and they won't throw their toys out of the pram (P9, Medicine, policy enactor)*

*Professionalism I think is very closely connected in that it requires you to uphold the standards of your profession. And in a profession where reliance is placed upon you either for advice or for making representations fairly, or for taking charge of things like assets, the concept of professionalism is wrapped up and bound up with your integrity. And most of what we refer to as professionalism as in turning up smartly, addressing people courteously, all that sort of thing, is closely allied to the presentation and the representation to others that we can be trusted and that we should be relied upon (P4, Law policy acted on).*

Trust, as a consequence of professionalism, could thus be demonstrated (measured and assessed) through meeting expectations of behaviour and language, the environment and context, and signals

such as dress and appropriateness. For those in the legal profession, conservative and formal dress was commonly cited as a key expectation, even despite recognising other professions becoming less formal. Participants in some areas of Law also referred to certain, long-established, professional rituals and formalities:

*Well it's - my job is so odd - so you know it's, you put on this kind of disguise. You put on the horsehair wig, you put on the robe, um, you refer to judges and fellow barristers in very formal language. There's loads of legalese bandied about in court. You stand up when the judge walks in, you know there's all of this process that is hundreds and hundreds and hundreds of years of formality and professionalism. Which - I think personally in my job, not in every job, but I think professionalism goes hand in hand [with being trusted]. So for example, you know, I wouldn't go into court you know smacking my lips with my bubble gum and you know saying 'hey' to the judge. Professionalism is about how you carry yourself in court and knowing of that history and abiding by the rules and leaving that kind of familiarity or any colloquialism at the door really (P24, Law, policy acted on).*

This social logic reinforced to our participants that demonstrating 'professionalism' was essential to gaining trust. It conceptualises a 'trustworthy' professional as someone whose behaviour can be measured, recorded and assessed. Moreover, as assessments of trust were recognised as subjective, it implies professionals must accurately know, and perform to, the expectations of the public and their patients/clients, in order to send the appropriate signals.

#### 4.1.3 'Trust' as individualistic quality

In their accounts, participants presented 'trust' as an individualistic quality: recognising that, when the patient or client enters into a professional relationship, trust is given or earned by the professional themselves (the service provider). Participants suggested that wider systems of regulation and accountability had little effect on their local relationships with patients and clients. Moreover, even the wider systems in which professionals worked (e.g. the NHS or the Law firm/Chambers) had little impact on the direct trust between practitioner and client/patient.

As a result, participants reported that, although the medical and legal professions as a whole were not always trusted by members of the public, in the vast majority of cases, individual professionals were nonetheless assigned trust when the patient/client entered into a professional relationship:

*Like people whinge about the NHS 'Oh the hospitals are bad, the NHS isn't that good' – but then if you ask them about their relationship with their GP or how their last hospital visit went, they usually say it's really good. So it's this dissociation about the individual relationships where the trust is still there, but they have diminished their trust in the grouping or the system (P30, Medicine, policy maker)*

*Whether or not most people would trust, for example, their real estate lawyer, I think they probably do. I think they trust the lawyers that they have interactions with. I think if you asked them if they trusted lawyers in general they'd probably say no. But I think they do trust the people who they have one on one interactions with (P1, Law, policy acted on)*

This separation of 'trust in the profession' from 'trust in the individual professional' supports the possibility for one to exist without the other. Therefore, participants understood that, in their relationship with the public, trust could exist solely in them as an individual ('a good apple') even if the trust in the profession as a whole was damaged or diminished ('a bad barrel').

However, the two were still connected, as the individual could be understood to enhance or damage the trust in the profession. For example, the good actions of individual professionals were understood to collectively feed into the 'good name' of the profession. This sustained the 'bad' and mediocre members who 'got by' riding this good faith in the profession as a whole:

*P15, Medicine, policy acted on: ...the one [reputation] that's earned is by good doctors that people can see who goes the extra mile, they come out in the middle of the night to see sick people, they give up their spare time, they work beyond 5, they're not watching the clock, so that, the doctors who do that, and they help build the reserve of trust in communities I think.*

*Interviewer: Mm, mm, absolutely. Um, and that's a nice, an interesting term that you used about building the reserve of trust, so that suggests that there's almost space of forgiveness for those that aren't as excellent as...*

*P15: Yes, they draw from that. They draw from that, they draw from that huge well that's built by history and good doctors, so you have the bad guys, not many, and then the average guys who just get by, but they feed off that well of trust.*

Likewise, individual professionals were also seen to have the power to damage trust in the profession as a whole. Participants referenced the purposive identification of individuals by the press, which emphasised this link between the actions of any individual as a reflection on the profession:

*Well publication of all the cases - Shipman for a start, and similar cases – and it makes people start to question. Whereas in the past I think the doctor was God. I mean my parents were both doctors and they never, well I say 'never', they were at a time when the doctor was thought to be right, and that was it. (P2, Law, Policy acted on)*

*Gina Miller - when she was trying stop Theresa May from not even letting parliament vote on any deal - was successful in the Court of Appeal, which must have been the divisional court actually, but the three judges there, and then again in the Supreme Court, and the Daily Mail had a front page picture of the three judges with the headline 'Enemies of the People' – I mean that is just outrageous – it's outrageous, and that doesn't help you know. (P12, Law, Policy acted on)*

Within this logic, trust in a professional cannot be assumed due to his or her membership to a profession, rather, each individual professional is positioned as responsible for protecting and boosting client/patient trust in themselves through maintaining professional relationships. Furthermore, although collective trust in the profession may help individuals protect their professional image, the responsibility is also placed on them to go "the extra mile" (P15) to maintain this good reputation as a protective 'buffer'.

#### 4.1.4 The fragility of trust

Participants reported a clear sense that ‘trust’ was very fragile: that once lost, it was extremely hard to recover. It was therefore seen as extremely important for professionals to maintain patient/client trust in their professional knowledge and abilities. The actions required by professionals to do this, were broadly understood by participants to be:

- 1) Listening to patient/client needs and involving them in decision making
- 2) Establishing common goals (achieving the ‘best interests’ for the patient/client)

With regards to the first point, participants in both professions cited similar strategies to demonstrate that they listened to, and involved, the client/patient in decisions. However, there were some substantial differences between the professions regarding the second point, as common goals were perceived to be established differently given the different contexts of each profession.

In summary, medical professionals were conceptualised as operating a public service, which held the best interests of the patient at its core. As a result, it was automatically assumed that both parties held a common goal from the outset. Patient trust was therefore also automatically assigned to medical professionals and it was then their duty to maintain this. Public trust in Medicine as a whole was thus perceived by participants as buoyant. In contrast, legal professionals were perceived to be operating for (financial) self-interest and it was therefore assumed that this might clash with the clients’ best interest. Legal professionals therefore had to gradually earn their clients’ trust over time. These processes are described in more detail below.

##### 4.1.4.1 The fragility of trust in Medicine

In Medicine, trust in the professional relationship was conceived of as something to maintain, rather than something that had to be earned. In the vast majority of cases, trust was understood to be given to the partnership by both sides at the beginning of the relationship. It was then up to the doctor to maintain this trust, knowing it could be lost. Participants reported that they listened to the patient’s needs, and tried to involve them in the decision making process about their treatment to demonstrate the maintenance of the partnership:

*I think, on the whole, the profession is imbued with trust and it is definitely for us to lose, although modern communication is pushing at that door, you know ‘I’ve looked at Doctor Google and they say this’. And I think that one of the ways in which you counter that is ‘Oh that’s a really interesting idea, you know let’s work through why that might be an option – or it might not be’. But if you say ‘Look that’s a load of bog’, then the person may think ‘Mm, not sure, not sure this person is really listening to me’ (P27, Medicine, policy maker)*

*So trustworthy, first stage, is [that] listening is very key to trust - and when I mean listening I mean hearing. Because if the only thing that you demonstrate is you’re only in it for you, then individuals can immediately think well what’s this all about. (P6, Medicine, policy enactor)*

This initial provision of trust was considered ‘obvious’, as from the outset it was automatically assumed that both parties would be working towards the shared goal of improving the patient’s health (above any other motive). The apparent obviousness of this related to the perceived altruistic nature of Medicine and medical professionals: that medical professionals are individuals who operate without self-interest and provide a *public* service (i.e. there is usually no financial transaction):

*The health system is largely publicly funded. So people think a highly trained doctor could have been a banker, they could have been a lawyer, if they had their own interests at heart they would have probably gone and done something that would have made more commercial sense for them, and they could then you know buy a yacht or whatever. But they don't, they choose to work for the betterment of societal health or for the betterment of individuals and maybe sacrifice some of that potential earning power (P1, Law, policy acted on)*

Indeed, when things went wrong the profession seemed to be given the benefit of the doubt because it was seen as a well-intentioned but poorly funded public service:

*I mean you will get, obviously about A&E, but people will say well I waited four hours, but at the end of it I felt I was dealt with properly. What a pity these poor people, you know, don't have more resources. Not a feeling that, you know, I was badly treated by and large, that's what my friends you know are telling me and that's my impression, so you know the trust of the professionals has not been undermined by the fact that services are pretty stretched (P20, Medicine, policy acted on behalf of)*

In contrast, when a financial transaction was brought into the doctor/patient relationship this sense of a service partnership, of working together towards a common goal, could shift and 'trust' was seemingly diminished:

*It [private healthcare] was a really unpleasant experience of just not - and then one of the - the anaesthetist came to see me - I got wheeled down to the operating theatre, and literally as I was lying about to have the first shot, the anaesthetist says to me 'Well you know I gave you that price earlier for the anaesthetic, well the thing is I've been talking to the surgeon who reminded me that this is a recurrent condition, so I'm afraid it's going to be a bit more - is that all right?'... He's just about to put me to sleep... we're having a conversation about money. And it's only like a few tens of quid difference in the price for the anaesthetic. And thought I feel like I'm being absolutely milked for money... So all of this obviously - you know bringing this back to the theme of trust, I just didn't - the trust levels were so low, and I would never go back to private care unless it was really, really important to do so (P26, Medicine, policy maker)*

In the public system (the NHS) it was, however, perceived as difficult for the public to lose trust in the profession, or even their own professional – even in situations where participants expected it to be lost, such as during moments where this altruistic image could have been shattered:

*So there's not many periods in your life when you're not in contact with the medical profession in some way shape or form. So it sort of refuels itself I think quite quickly, because what you work out is that most of the time doctors are acting in your best interests and you forgive them. I think if for example it became clear, and there's been a bit of it at the moment about pensions with consultants, there's a small minority of the public that are saying 'Hang on a minute, these people are getting paid a whole lot of money' - they hadn't really quite realised it. So I think as it stands, the professional has survived, even the junior doctors' dispute, I think it survived that, certainly MORI seems to suggest that it stays there. (P6, Medicine, policy enactor)*

*I mean there's people like Dr Shipman, you know he was loved by his patients. And even after he was you know outed, people would still say 'Oh he's a lovely doctor', and you think 'Okay'.*

*So you know I think trust once given, you know it's an extraordinarily powerful thing isn't it?  
(P8, Medicine, policy enactors)*

#### 4.1.4.2 The fragility of trust in Law

In contrast to Medicine, in the legal profession, trust in the professional relationship was seen as something to be earned rather than automatically given. It was generally understood that legal professionals needed to build trust in the partnership using their ability to listen and involve clients, and to do this over time:

*So for example by taking client instructions on the original report and writing a really strong response and then sending it to the client to look at - that would be another opportunity to gain trust, you know you won't always be able to include everything that the client's instructions would suggest, so there's limits to it. But yeah there's also definitely ways of gaining that trust which you know at least hopefully in the majority of cases are useful (P12, Law, policy acted on)*

*Yeah, I mean to give you an example...the first time I met this kid, and he is a kid, he's 16, um, in prison to meet him before his trial started, he didn't trust me beyond giving me the barest bones of what he wanted me to do for him in his trial. So he gave me some very, very sparse instructions. Um, but as the weeks have gone on, and as we've formed a relationship. And I see him every day at least three times a day in the cells at court, and he sees that you know I'm doing my best to present his case as properly as I can. His trust has built and he's gone from calling me Miss to [name] and you know he smiles when he sees me and he sends me notes when I'm in court... So also, it's sort of it's not simply saying the right thing, but it's doing the right thing and showing the client that you're doing the right thing or the best that you can for them in that sense (P24, Law, policy acted on)*

Participants thus felt trust in legal professionals needed to be *demonstrated* to be built, as it was not clear that both parties were working towards a shared goal, especially as it is assumed there are financial benefits:

*So you go into that [employing a solicitor] knowing that they're self-serving, and all of the conversations that you're having you've got it in the back of your mind – this is about their commission - whether that's right or wrong, you know, for them. So I think it's, you can to some extent, but the more it's seen to be self-serving, the less likely the customer's likely to buy into it, like the service user. (P6, Medicine, policy enactor)*

The assumed motivation to make money was a powerful narrative participants strongly associated with the legal profession, believing this to be heavily reified in society. There was a distinct sense amongst participants that the public did not trust the profession in general because of it:

*Interviewer: Do you feel that the public trust legal professionals?*

*P2, Law, policy acted on: No (laughs) And I think probably ... they don't like lawyers in general. But I think there's also - there's a financial part of that, I think a lot of people [assume that] lawyers are just making a fast buck at their expense...*

*and I think the public are aware of that. Again it's publicity. I mean everything now – you hear about everything all the time, whereas in the past one didn't.*

*Doctors and solicitors look similar, they often behave in a similar way, their qualifications are similar. No I don't think I can think of any particular thing that would make doctors more trustworthy than someone in the legal profession... except for the profit. (P28, Law, policy acted on behalf of)*

This underlying distrust means the professional relationship is far more fragile than the doctor/patient one and can be more easily dismantled. For example, it is assumed that when there are financial benefits from taking a case, the desire to profit will eclipse other (more trusted) motives for creating a case:

*I mean I remember once I was speaking to a friend about - I think it was like the Bloody Sunday Inquiry... and they were sort of saying "oh you know it's problematic, like a lot of lawyers like made a lot of money out of it." And it is a bit like saying: "oh this operation's problematic cos a lot of doctors made a lot of money." Again I'm not saying it's exactly the same, obviously with doctors it's life and death - yeah. But there is - like it is a bit - yeah there is just a very different - yeah there is just, quite sort of, strange things round it, suspicion around those kind of cases. And you know in fact personal injury cases as well, it's very much you know the idea that like there's a compensation culture and things like that (P12, Law, policy acted on)*

Likewise, legal professionals felt they were not given 'the benefit of the doubt' regarding their intentions, unlike other professionals:

*Yeah I mean, when they go after to doctors or the police or whatever – it's never them, it's their bosses – they don't accord us that kind of respect, they don't say 'I'm sure all your lawyers would love to do the right thing'. Whereas if they attack the police it's 'They're restricted in what they can do by...' blah blah blah. Nurses are obviously – everybody loves. The doctors are fine, it's not them it's the administrators, they're evil. But they don't make that same allowance for us. Occasionally you'll get someone will say I'm sure it's just that you haven't got the budget. And if I say no, well then I'm just a liar – because they want to believe that. (P10, Law, policy acted on)*

Similarly to Medicine, legal participants reported that public scandals rarely shook, or further reduced, the underlying level of trust in their profession. Moreover, they referenced fewer high profile scandals which they felt might have impacted the public trust in Law. Instead they expressed a continuous erosion of trust in their profession more generally:

*Um, I can't really think of any sort of critical events that have affected the way that people think about trust in the legal profession. I think that there have been, I think generally, and I know this, it sort of lacks any real specificity this answer, but I think generally there has been an erosion in trust in professionals generally, but it's difficult to pinpoint sort of critical events within that. Um, I do get the sense that there's a sort of general trend towards people having less trust in professionals. (P19, Law, policy acted on)*

*I mean a) lawyers don't kill people I suppose, not directly anyway, and it's quite rare for, so the things that lawyers if you like get into really serious trouble for are generally things like stealing their client's money and so on and so forth. That can affect quite a large number of people,*



*but it's not really national news, it's more local news in those contexts... sometimes it's just quite hard to really pin things on the lawyers for a whole bunch of reasons. Yeah, there's just not the focus of interest in the same way basically. (P11, Law, policy acted on)*

## 4.2 Political Logics

In this section, we consider political logics. As discussed in Chapter 2, these sit within the 'political dimension', where the contingency of reality becomes apparent, and can be contested. For example, beliefs which are normally unquestioned, might suddenly appear to people as just that – a created and changeable belief, not a fixed 'reality'. In this moment of dislocation, ideas about 'reality' (social practices) can thus be discarded or reformulated.

Political logics are therefore attitudes and beliefs that either challenge or defend social practices (and the 'reality' these present). In our data, two political logics stood out as key: the first questioning the importance of trust; and the second questioning the need to demonstrate trustworthiness through transparency. These will be explored in detail in the following sections.

### 4.2.1 The political logic of the importance of trust

The importance of trust in creating and maintaining effective client and patient relationships was deeply embedded in participants' accounts (see e.g. 4.1.1 and 4.1.4). Although these beliefs were therefore widely accepted and unquestioned, participants occasionally referenced a different 'way of thinking' in which public trust was not seen as essential to performing their role, or to ensure the public's continued use of their profession. This revealed itself through the argument that patients and clients have 'no choice' but to use professional services:

*And hard as it sounds, the public aren't going to have a lot of choice.... When it comes to the public, whether or not they trust us, they've got nowhere else to go to a certain extent - it's cynical but it's the reality. (P10, Law, policy acted on)*

*You know we have to trust that their medical judgement is good, and it's rare that you know, as a patient you hear scandals don't you, but it's rare as a patient you would ever really know, be able to assess the clinical competence of the GP who is looking after you. (P20, Medicine, policy acted on behalf of)*

The patient and client vulnerability and dependency was commonly referenced here, as it was acknowledged that they lacked professional expertise, and accordingly, lacked power in their level of 'choice' in assigning trust to the professional. This was particularly voiced by those in Medicine, as participants noted that doctors were relied upon in the most essential of situations (e.g. to preserve life). Although the essentially of service was less strongly observed in Law, there was still an acknowledgement that clients had 'no choice' to engage with the system if they wished certain outcomes (e.g. to buy/sell a property or were faced with a criminal charge).

The logic that the public have 'no choice' but to use the services of professionals, sits at cross purposes with the notion that trust is 'essential' to create and maintain professional services. Why is maintaining trust – particularly in the profession as a whole – important, if the public have no choice but to utilise their services? If the public is totally dependent on the expertise of the professions to

improve their situation in times of intense vulnerability, why is trust in these professions relevant, when to utilise their expertise is a public necessity? This way of thinking disempowers the public (portraying them as dependant and without the ability to choose) and questions the importance of trust in the profession.

Our participants dealt with this challenge to the importance of trust by using a political logic of difference – when the challenge was highlighted, they did not attempt to reconcile it (e.g. using a logic of equivalence, see p.23), but rather silenced the deviant perspective, by returning and giving precedence to ideas that stressed the crucial aspect of trust, thereby distancing themselves from incompatible ideas.

This ‘distancing’ effect was emphasised by participants’ use of ‘othering’. This invoked ‘us’ and ‘them’ rhetoric to create two broad, identity categories: ‘good professionals’ and ‘bad professionals’. ‘Good professionals’ were shown to provide a high-quality service to their patients and clients and to prioritise trust relationships. They were also seen to be the majority within the profession, and participants’ aligned themselves with this group (‘us’). Simultaneously, participants distanced themselves from the group of ‘bad professionals’ (‘them’), implying or stating that they did not share their ethical values, and were thus at odds with ‘good professionals’ and the profession as a whole:

*I think that compared to other groups that doctors are trusted, partly, it's partly historical and obviously there is a lot of, some of it is, it's not a, some of it is historical, and also because doctors are in contact with people who are extremely vulnerable, during times of great vulnerability, when in fact people do not have a choice. You know you've got a big cut in your abdomen and there is only one guy who can stitch it. And you can't, you have to then trust him whether you like it or not, so it's a kind of self-fulfilling prophecy I think, so that is, so the trust of doctors is multifactorial. I think it's historical, it's also because patients are, or clients are particularly vulnerable and, in a sense, there is no plan B for them and I think that some of the guys who are good doctors, really good doctors learn the importance of trust and I think that that percolates historically. The word gets round in the community that you know they're good doctors and people see that. But - I don't know how many there are - the doctors who are bad, the doctors who don't care, the doctors who shouldn't be doctors and they're there and they push back on the trust, diminish it. (P15, Medicine, policy acted on)*

The key difference between these categories of ‘good’ and ‘bad’ professionals was implied to be their demonstrable ‘professionalism’ and their pursuit of trust. In section 4.1.1 we noted that participants felt that being ‘trusted’ was important in order to provide a service and satisfaction to the service user. In this political logic, a ‘good professional’ provides a *good service*; a ‘bad professional’ provides an *inadequate* service. A ‘good professional’ increases trust in the profession as a whole; a ‘bad professionals’ neglects or diminishes this.

There was a considerable difference in the perceived prevalence of ‘bad professionals’ between the professions, with the perception that this was a greater issue in Medicine than in Law. This was perhaps related to their awareness of, and opinions about, public scandals in each profession (see 4.1.4.1 and 4.1.4.2). The existence of these identities appeared to be deeply interwoven into public scandals in the profession, where ‘rogue’ professionals behave in unprofessional, untrustworthy ways:

*I think generally speaking it [Law] is a trusted profession, because very rarely in fact do you find anything in the press about a barrister you know being prosecuted for any misconduct or*

*perhaps you know being caught up in some sleazy scandal. Generally speaking, um, well of course you have the odd bad apple, but generally speaking those stories are very few and far between (P24, Law, policy acted on)*

*I think the hyponatraemia inquiry [Inquiry into Hyponatraemia-Related Deaths, 2004 -2018] is a very awful protracted story of doctors getting things wrong, that's not the problem – the problem is the closing of ranks, the frank deceit and lying that we've seen by a lot of doctors over a long period of time. I'm sure if you were to explore this in Northern Ireland you'd find has had a miserable impact on people's beliefs and attitudes towards doctors. (P29, Medicine, policy maker)*

These distinct and mutually exclusive identities of the 'good' and 'bad' professional can therefore be seen to create divides amongst professionals, creating a more individualistic environment and promoting a social logic which posits trust as an individualistic trait (see 4.1.3).

### 4.3.2 The political logic of transparency

As discussed above (4.1.2), modern professionals saw the need to demonstrate professionalism to maintain their patients'/clients' trust. Within this was an emphasis on demonstrating the importance of honesty and transparency on the part of the professional. Nonetheless, whilst accountability and standards in the one-to-one relationships were positioned as integral, participants criticised the effectiveness of the formal regulation of professionalism:

*I think 'the profession' are seen as an honourable group. I think regulation is something that's been introduced by regulators, by policymakers, by the government on behalf of the public, acting in their interest, but I don't think it's necessarily increased the professionalism of the profession (P9, Medicine, policy enactor)*

In relation to Medicine, the stringent requirements to consistently demonstrate 'professionalism' were commonly questioned, and frustrations around the regulation of the medical profession surfaced, particularly in relation to bureaucracy, effectiveness and intent:

*I think it's probably quite poor to be honest in the way that it's currently done. I think there's a lot of tick boxing that doesn't necessarily show clinical practice, it shows that you might be very good at paperwork. I'm in a profession [specialty] of physicians who are notoriously very poor at the portfolio side of it. Often my colleagues are all in a very similar boat at the end of the year trying to rush and get things done. But I know people who have struggled with portfolios who are very, very good clinicians and therefore judging them off a portfolio seems very harsh. (P16, Medicine, policy acted on)*

*I think they're [the regulator are] always trying to find the worst to show they're doing a good job – it feels like that. It doesn't feel a happy relationship. And I absolutely accept that doctors should be regulated and I think self-regulation has had its day, we don't need that. But you know, does it need to be heavy? I personally think performance appraisal and CPD are all good things, and as part of your licence to practise it's not unreasonable to produce evidence that you've been through that – I think that's perfectly reasonable. But a lot of bureaucracy, and*

*don't hide behind that saying you're safe and you're good, cos it may well not prove it. (P30, Medicine, policy maker)*

Although the fundamental need for regulation was thus recognised and accepted, these accounts highlight that the current regulatory requirements could make 'good' doctors look 'bad'; as well as potentially help 'bad' doctors provide evidence that they are 'good'. This can be seen as a challenge to the role of the regulator as the conduit for the public's expectations of professionalism and as the enforcer of these expectations, as it questions their effectiveness in these roles. These frustrations also challenge social logics claiming that professionalism must always be measurable and measured (4.1.2).

To rebalance this 'clash' between frustrations with the regulator and their beliefs about the need for demonstrable professionalism, participants from Medicine and Law, once again, drew on the 'othering' rhetoric of the 'good professional' and 'bad professional' (see 4.3.1). The regulator was seen as essential to identify and remove 'bad professionals', who committed extreme breaches of professional behaviour, such as issues relating to fitness to practice:

*I think having a vocal regulator I think is important, I think it does gain trust. I think again, again, I think having someone that actually oversees that doctors are doing the right thing and that there are disciplinary proceedings and there are ways in which sort of poor clinicians or people who have done something wrong are sort of dealt with and that's picked up (P16, Medicine, policy acted on)*

*if you see most barristers or whatever that end up in the papers because they've been struck off, it's because they've ended up having a relationship with a client that is incredibly improper, or they've stolen, you know it's not that they have slightly fallen below what we would all call is a good standard, it's because they've stepped right off the reservation and done something stupid. And they get caught in other ways and then the professional body comes in. You know it is rare that somebody is significantly disciplined just for not being very good, it's usually because they breach what society would say is improper behaviour never mind the bodies. (P10, Law, policy acted on)*

In contrast, for 'good professionals', self-regulation was sufficient and the regulator was thus a distant presence, which created a transparent system in which 'good professionals' had nothing to hide and 'bad professionals' were removed:

*But my feeling is that there is a lot of self-regulation that goes on. I think that's because of the way doctors are trained and because of the history and because of the fact that it's largely an apprenticeship. It still is an apprenticeship and people learn from their seniors or their bosses and copy them and they self-regulate. I think that is the thing here in this country, um, and I think that the GMC is there for very bad people. (P15, Medicine, policy acted on)*

*So, I mean I think without that [regulation], how could the public ever have confidence that the group of people or the person that's providing the service to them isn't sort of a bit of a rogue one? Because if there was no regulation they wouldn't have been weeded out of the system (P23, Law, policy enactor)*

This logic again individualises 'professionalism', portraying the individual as responsible for upholding trust in the professional relationship (4.1.3). For 'good professionals' heavy regulation is reduced to

an inconvenience, but necessary for a 'greater good' - identifying 'bad professionals' and thereby maintaining public trust in the profession:

*You know people will complain won't they to an extent just cos it's got to be done and they don't feel they've got the time to do it - we all like complaining about anything we don't really want to do... Particularly you know if we think we're alright and we just feel we're doing it just because it's got to be done. Yeah. So I don't know, but maybe doctors do feel the GMC is very oppressive. I mean I do know some doctors have very strong views about interfering and all the rest of it, but whether they, the extent they wish it weren't [sic] there at all, doing anything, I somehow doubt it... they really don't like the idea of their professional performance being regulated, and things like you say, you know, having to complete the portfolios – it's all of the administrative tasks, there's lots of griping about that, but they absolutely recognise the need for the regulation of the profession. (P2, Law, policy acted on)*

*I think the general public would trust doctors, and they expect, they expect, like they expect air traffic control, and they expect pilots, and they expect the bins to be collected – they expect these things to happen, and assume that the pilot knows how to fly, the doctor knows how to doctor, and that the bin man picks up the right bins on the right day... I think they accept doctors as knowing that they've gone through quite a long rigorous training, there are lots of bars for them to learn to climb over, that somebody somewhere is keeping an eye on them. Yes, when revalidation was introduced patients who were surveyed said they were very surprised and shocked that doctors were not undergoing regular checks and balances and appraisal – they expected that that's the way it always had been and they didn't realise that doctors weren't checked. (P6, Medicine, policy enactor)*

As mentioned above, there was a strong difference in the perceptions of regulation between the two professions. In both professions, the heavier regulation of Medicine was acknowledged and justified according to the level of vulnerability of clients:

*So maybe there is a greater emphasis needs to be put on being sure doctors are working at the level they need to all the time. Whereas with the Law because you haven't, you know, no one's going to die as a result of you getting something wrong as a lawyer. Or I mean not necessarily die, but you know, it's only money that's going to go probably if the worst comes to the worst. (P2, Law, policy acted on)*

*The situation with doctors is that I think there is more scrutiny, so it's not just about whether you're honest or dishonest, but it's also about your self-control, any evidence of lack of judgement, obviously anything where you would injure somebody, but that all plays into trust as well in Medicine – more-so than in Law I think. Because you're physically vulnerable as a patient, you're not physically vulnerable as a client most of the time... So there's such a heightened vulnerability as a patient compared to a commercial client that it makes sense that there would be a much higher scrutiny over your behaviour in general, not just purely related to dishonesty. (P1, Law, policy acted on)*

### 4.3 Fantasmatic logics

As discussed in Chapter 2, fantasmatic logics are used to reinforce and maintain social practices, and their associated social and political logics using emotional and ideological 'promises'. In this context, beautiful promises tell of desirable rewards for adhering to the practices and logics of the current beliefs and organisational principles of the professions; whilst horrific promises foretell of undesirable effects should these systemic 'rules' be broken. In this way, fantasmatic logics are used to 'grip' actors to the 'reality' that they are currently presented with - promising them good effects from thoughts, beliefs and actions that conform, and warning them of dire consequences from those that do not. An analysis of fantasmatic logics thus helps to reveal what might have motivated our participants to support and maintain the logics described above, as well as believe in the subsequent social practices.

#### 4.3.1 The horrific promise of untrustworthiness

In 4.1.4 we explored social logics that emphasised the importance and perceived fragility of trust in professional practice. These logics claim that establishing and maintaining trust within professional relationships was achieved by listening to a patient/client needs and working together towards a shared goal (p.53). Strongly reinforcing these logics, within participants' accounts, we found horrific promises of bad things to come should 'trust' be lost.

Participants noted the negative effects for the individual professional should trust be lost in the relationship:

*I think it's really important than I'm trusted because otherwise you don't have that positive working relationship. And one of the reasons why I would be able to walk away from a case is if I felt that there wasn't the trust and confidence that the client is entitled to have in me. (P22, Law, policy acted on)*

*Well I think it is important. I mean I think it's probably, as a physician, I often say to my trainees that the only way you can get a proper history from a patient is that you have to earn their trust. They have to trust you enough to tell you some of the deeper secrets, and if you can't do that, you will always have a fairly poor understanding of the patient's problems and that is a big problem yeah. (P15, Medicine, policy acted on)*

In these examples, participants reinforce the importance of trust in the relationships with client or patient, through the threat of having "a big problem" if unable to earn trust; or being obliged to terminate the partnership if they are unable to provide the client with trust they are "entitled to". The detrimental effect of a lack of trust was also presented from the patient/client (service user) point of view:

*If you're getting advice from anybody you want to go into that office thinking that you're going to come up with some gem, not some rotten apple – it's still got to be nice and crunchy when you bring it out. So, no - you have to have trust in them and if you don't there's no bloody point in going to see them, you might as well talk to your gardener. (P25, Law, policy acted on behalf of)*

In participants' accounts, there were also horrific logics used to counter the deviant idea that trust was not essential to maintaining the professions more widely (see 4.2.1):

*Like I think the anti-vaccine movement is probably a really good way of demonstrating that. So you've got this group of people who their faith in the medical profession has absolutely disappeared, and they believe that there's some conspiracy involving big pharma, and that because of that doctors are pumping poison into their children just for the sake of money - again it comes back to this commercial point. And then what happens? Well you get resurgences in the diseases that were pretty much eradicated years ago. If that became like nationwide or you know an epidemic of lack of trust in doctors, the health implications and like impact onto society because of those health implications is really significant (P1, Law, policy acted on)*

*That it's really important the public trust the justice system, because if there is no trust in the justice system that we all get fair and just results, then we really are dancing on a cliff edge... Because as soon as people stop trusting in our courts and our justice system and our police and you know the crown prosecution service, we are likely to face mayhem (P24, Law, policy acted on)*

In these emotional appeals, participants threaten “mayhem” and serious adverse health emergencies as a result of the professions not maintaining the trust of the public in the whole.

Horrific promises of untrustworthiness also knitted together the role and responsibility of each individual professional in maintaining the overall trust in the professions (see 4.1.3), and thus to reinforce the political logic that tough regulation was needed to ensure that every individual was a ‘good professional’ (4.3.2):

*I don't think that it's fair, but I think it's like, people just have to be held to unfairly high standards when they are in such a position of trust. And like I think it was monumentally unfair what happened to both of those individuals [by the regulator], and many others I named just now, but at the end of the day the public trust in the profession – if that goes then the repercussions, the repercussions would be unthinkable. You know public health would go out the window, like the relationships between the patients and the doctors would just totally break down (P1, Law, policy acted on)*

Together, these fantasmatic logics work to provide ‘horrific promises’ of the consequences of lost trust, both in individual professional-client relationships and within the professions as a whole. These therefore reinforce the understanding of trust as essential within a social ‘partnership’ with society, in which the public has the power to damage the fundamental and established structures of the professions if their trust is not earned and maintained through a high-quality service partnerships. Moreover, these horrific promises reinforce the position of the regulator – ensuring most practitioners are ‘good professionals’ and enforcing punishments to make examples of ‘bad professionals’ to the public.

#### 4.3.2 The horrific promise of unprofessionalism

In 4.1.3, the social logic emphasised how participants saw demonstrating ‘professionalism’ as essential to gaining trust. This was reinforced in section 4.2, by participants’ use of political logics to promote the key importance of being considered a ‘good professional’, who believes in the importance of trust and transparency. In this section we explore how these logics are reinforced by fantasmatic logics.

Participants strongly felt that if public expectations of professional behaviour were not upheld, then the client/patient can lose trust in the professional working for them:

*If you're a solicitor going into court now you won't have a wig, whereas in the crown court they expect wigs. So there are expectations. Our in-house advocate as we call them, they are ... you know so they're working for us – they don't wear wigs, so that's seen as 'He's got a wig on their side, why hasn't ours got a wig? – I haven't got a real barrister'. (P10, Law, policy acted on)*

*A non-business orientated doctor... makes a choice for you [the patient] in your best interests you know they're doing that... because they want you to have it cos they're thinking of you. Whereas I think what doctors are faced with now is - because of the business model and the commissioners - and if they're too business-y on the other end of the spectrum [with patients], they will not mention choices that are available to you, so they'll keep ideas back, and services that they don't have, back from you. And if they begin to look like they're only offering what their organisation was funded for, they're only offering me what will make, no not make them a profit, it's only offering me what they have, what their business provides and is best for their business – that's when you begin to think they're in this more for themselves rather than me. (P9, Medicine, policy enactor)*

In Medicine, meeting professional expectations were again linked to the public expectation that doctors were altruistic and would always act in their patients' best interest (see 4.1.4.1). There was therefore a threat of a loss of trust, if this altruistic image is challenged (e.g. when doctors' professional behaviour had to reflect the business-requirements and limitations of commissioning/funding).

Within medical participants' accounts, there was also a pattern of uncertainty around the extent to which medical professionals needed to demonstrate 'professionalism' in their private lives (4.3.2). Horrific promises were used to suggest negative consequences for who did not behave like a 'good professional' both in and out of work:

*I think if you're in a position where people have to put trust in your, I guess the conduct of which the general public see you at out of hospital, they would then see you in hospital and they know that you've been drunk, or made a scene somewhere – they're not going to, you're instantly on a back foot when it comes to a patient doctor relationship... their perception of you is going to be much lower than probably it should be. (P16, Medicine, policy acted on)*

*35 years ago when I was at medical school I could go out and do the XX [pub crawl], do the 10 pubs with you know a pair of underpants on my head, and it was never preserved for the future, and my professionalism wasn't called into - in fact it was almost expected of me. Whereas now if medical students do that sort of thing and it gets onto Facebook they're up in front of the dean for breaching professional behaviours, you know in their own time away from work. (P28, Medicine, policy maker)*

These high standards were linked to a perception of the increasing expectations of the public, and a horrific promise that, as doctors, they are subject to increasing public challenge as well as scrutiny by their regulator:

*And then as society has become more challenging and more aware of error and less tolerant of it, less tolerant of variants of practice, it's become - first of all doctors are being challenged*



*more frequently and it's become harder for them to keep up to date as knowledge expands exponentially on a continual basis. And those grey lines of are you doing enough to keep up to date and are you doing your work as diligently as possible, those grey lines are becoming ever more blurred and more difficult. (P28, Medicine, policy maker)*

Participants in Medicine and Law justified the high behavioural standards required of professionals, by referring to horrific promises about the high vulnerability of the client/patient and thus the higher potential for harm, should their behaviour not meet these standards:

*I think the standards that are expected of you are, they are different, because of the particular other peculiarities of dealing with vulnerable individuals and the need to ensure, I can't even think of the word, but there is a fragility of trust there, I think it's much easier to damage the trust that you have if you're dealing with vulnerable people... because they may not have their own voice, they may not be able to articulate things in the way that those who are less vulnerable would. And I think that the trust can be much more easily and quickly damaged if something goes wrong when you're dealing with someone who's vulnerable. (P22, Law, policy acted on)*

Rejecting acceptable professional behaviours was positioned as substantially risky for the individual professional, with the threat of removal from the professional register for inappropriate behaviour. Cases that had led to media scrutiny and scandals were commonly cited. In line with the logic described in 4.1.3, the disgrace of an individual professional was also seen as a risk to the profession as a whole:

*So if you're a herd of wildebeest for example, you want to stick to the rules and norms and values and not stray off the beaten track, because if you do you basically run the risk to yourself and also run a risk, there's a risk to your herd, so it's a set of rules which you stick to because you're part of a group. (P15, Medicine, policy acted on)*

*So you know that's [the Shipman case] often paraded at the meetings, the conferences we have, and more recently of course there has been the, I've forgotten his name, but there has been the breast surgeon [Ian Paterson] who was doing unnecessary operations, and again that is part of the training of responsible officers... certainly he [Paterson] is used as an example, a very key example in warning responsible officers that, of their duties you know, not to take the easy line if you have a strong willed colleague who you are concerned about or others are concerned about (P20, Medicine, policy acted on behalf of)*

Horrific promises were notably more common within the accounts of participants within Medicine, giving the impression that the 'horrific promise' of unprofessionalism weighed substantially heavier than in Law.

### 4.3.3 The horrific and beautiful promises of regulation

In 4.3.2, we explored participants' beliefs about the need to be seen as a 'good professional', and how this political logic worked to appease tensions surrounding the regulation of professions – positing 'adhering to regulation' as a necessary process to ensure transparency and trustworthiness. Also countering these challenges to regulation, were numerous fantasmatic logics within participants'

accounts. These promised improvements and desirable consequences if regulation was adhered to, and threatened negative consequences if regulation was removed or reduced.

Within both professions, participants' referenced beautiful promises that regulation not only maintained, but could also improve the profession – increasing public trust through auditing and transparency:

*I think the purpose of regulation of professions is to ensure a certain standard and quality, and like the standards could be anything from hard skills to very soft skills. And I think as a by-product of that, because you have that kind of auditing of professionals, I think it will increase the trust in the system. (P1, Law, policy acted on)*

*Well I'd like to think that the regulator really bears down on its professional group to improve the performance that they give to the public. And if we do that in a meaningful way and really challenge the profession to keep their standards up, to learn, to develop themselves, then I think the public will feel that they can trust the profession. (P27, Medicine, policy maker)*

Fantasmatic logics claimed to prevent 'bad' behaviour through regulation. For legal professionals, bad behaviour was often posited as making a financial gain for services rendered, therefore regulation centred predominantly on financial malpractice. Horrific promises thus threatened that professional systems could not function without regulation holding professionals to account:

*I mean also you know if you're handling hundreds of thousands or millions of pounds in client funds, and no one's going to do anything to you if you steal a lot of it... well you might face criminal repercussions, but you know the system wouldn't work at all if you didn't professionally scrutinise a doctor or a lawyer who had gone so far off piste. (P1, Law, policy acted on)*

For Medicine, the vulnerability of the patient and the potentially extremely severe consequences of professional malpractice were highlighted within fantasmatic logics. This example threatens the horrific promise of the potential for "exploitation or abuse" of the vulnerable without sufficient regulation:

*I suppose one of the underlying principles of regulation existing at all is that patients are inevitably, there is inevitably some vulnerability when you are a patient because of your own personality or your own circumstances may make you more vulnerable on your own capabilities. But also innately being a patient means that you are consulting somebody's expertise who understands possibly what's going on in your body or in your mind better than you do, and that inevitably lays you open to exploitation or abuse should that person be so minded to do so. And that regulation is about correcting that imbalance between patient and professional and protecting people from being abused in that way. (P26, Medicine, policy maker)*

Horrible promises were substantially more frequently used in relation to Medicine, in comparison to Law. These horrible promises threatened a reoccurrence of scandals and high-profile malpractice events (see Table 3, p.90) if trustworthy practices were not formalised through regulation:

*You know back again to Harold Shipman and how much his patients liked him. Um, so it's not enough, but the fact that a patient does have confidence, have trust in their doctor is obviously*

*desirable... And the regulators, although it's easy to criticise the, you know the bureaucrats as it were, the politicians, the senior hospital managers and all that kind of thing, um, again it's absolutely vital. We can't just leave it to sort of happenstance. Otherwise again we're back to the fact that a charming doctor with good communication skills you know could be useless. I mean you do need you know formal regulations, formal appraisal, formal scrutiny and in the end that can't just be by your chums. You know otherwise we're back to you know some of the problems we had before (P20, Medicine, policy acted on behalf of)*

*So the level of trust - and you know horrible cases like Harold Shipman and the Bristol Inquiry and various egregious examples of dysfunctional behaviour causing great tragedy and harm - so I think the realisation was that doctors left to manage their own professional behaviours unsupported in the modern era was untenable (P28, Medicine, policy maker)*

Moreover, within Medicine, the need for strong regulation was also justified using fantasmatic logics. These claimed that if strong external regulation was not imposed on doctors, they would not abide by, or keep up with professional standards and expectations, and negative consequences would ensue. Regulation was thus positioned as a protective force, which helped doctors maintain professionalism, and make this demonstrable and transparent:

*So that was driven by the Law, you know the judgement in the Montgomery case which drove the whole difference. It didn't actually say that the GMC's guidance was outdated or wrong, it said actually the GMC's guidance is right, it's just that nobody was taking any notice of it... I think what happens is society's expectations shift, but practitioners are trained at a particular point in time, and their training - specially their professionalism training - isn't necessarily updated, it sort of has to be almost pointed out to them that the consequences of doing so now are so catastrophic for you as a professional, that if you don't do this, and then they feel beaten into some change rather than buying it. (P6, Medicine, policy enactors)*

*And indeed you know doctors were emerging from medical schools and starting to flounder very quickly because there was just too much for them all to keep up with... But by writing it down and doing it to a certain standard, then that's a significant step towards showing the regulator and hence the public that you're engaged in professional behaviours and you understand the need to keep up to date, and that you're sort of providing some information about what you're doing about it. (P28, Medicine, policy maker)*

#### 4.4 Social practices - the current 'reality'

Having discussed the social, political and fantasmatic logics that inform and shape our participants' 'ways of thinking', we now come to discuss how these may shape their conception of their current 'reality' – both what 'is' and what 'is possible' within their understanding of what it means to be a modern profession.

Social practices are beliefs and actions we do almost automatically, as they are embedded in our norms and everyday patterns of thinking: "largely repetitive activities that do not typically entail a strong notion of self-conscious reflexivity" (Glynos & Howarth 2007, p104). These practices are strongly influenced by our contexts, and when performed, in turn also influence our contexts by

further reproducing and reinforcing the patterns of thinking. By drawing out these practices, we provide insight into how our participants understood their 'reality' as a modern professional.

In this section, we present two social practices that were described by participants as the way in which professionals enact these logics in order to build or maintain 'trust' in professionals: the 'reality' of service provision; and the 'reality' of demonstrating accountability. In this section we also explore how the logics of trust build an understanding of professionalism and regulation.

#### 4.4.1 The 'reality' of service provision

Social practice for medical and legal professionals was predicated on the notion of service provision. Interwoven into participants' accounts was the concept that both medical and legal professionals provide a service, and therefore are themselves 'service providers'. Their approach to service provision, to providing an effective and consistent service, was tightly linked with the notion of professionalism:

*So professionalism means acting in a way that's consistent with the expectations of others that share the same profession, but also those that use the services of that profession... what others in that profession would expect for you to do or behave, what the service users or people that might access those services would expect you to do, but also the rules that that organisation has (P6, Medicine, policy enactor)*

*To me [professionalism] means behaving to the same high standard and in the same way to all the individuals who engage with you, be they other professionals that you're dealing with in your day to day work, or those you're providing a service to... that you'll maintain the same level of high quality behaviour and service in all circumstances, as far as is humanly possible (P13, Law, policy acted on)*

This way of thinking conceptualises the functioning of the professions, and professionals' relationships with their 'service users', in a transactional way (i.e. transforming the patient or client into a consumer or customer).

Participants were frequently critical of this transactional approach to professional encounters, and were aware that this was a relatively new conceptualisation of their role, breaking with the way the professions were thought of in the past:

*Yes a customer, a consumer, I hate it. I'm not either a customer or a consumer on a train or a client, I'm a passenger and I'm a patient, yes. Even when I was pregnant and I was healthy I was still a patient when I was in the hospital – just a healthy patient. Yes I think it has changed (P30, Medicine, policy maker)*

For some legal professionals, the reconfiguration was more marked and reaching the point of commercialisation of the profession, leading them to question whether it was indeed still a 'profession' rather than purely part of the service industry:

*So within the legal professions being a professional may mean that sort of slavish devotion to your client's interests and putting your client's interests above your own personal profit, or you know your interests. But then a lot of people now say well you know Law is a business it's not*

*a profession. So that professionalism in fact pulls against running a Law firm where you have to be focussed on making money, making profit, paying the bills and all the rest of it. I struggle with it slightly in that it can sometimes be used almost in a derogatory way in that sense by some (P23, Law, policy enactor)*

The impact of Law as a service that was paid for per transaction, had a striking influence on participants' perceptions of the profession.

Despite their discontent, our participants strongly acknowledged that 'service provision' was the 'way that things are now' (their 'reality') – accepting the dominance of this as the 'understood' way-of-working within their professions.

#### 4.4.2 The 'reality' of demonstrating accountability

Participants characterised a sense of professional accountability, gained through the formation of trust, as inherent to their concept of what it meant 'to be a professional' and to belong to a profession:

*Yes, trust in a professional, it's the idea that there is either an explicit or an implicit code of conduct and the public expects... all professions really to behave in a proper and ethical way. Partly to do with a set of written, you know, regulations that would be very explicit, but also just in a sort of general fairness sort of way. So - and the trust bit is mainly trusting that people will behave properly (P20, Medicine, Policy enacted on behalf of)*

*Within one's own profession I think it's abiding by what you have learnt it means to be - in my case a lawyer or a solicitor - and to know the parameters of what you do, and act within the limits of your competence. To be answerable to whatever you say, so that - well I'm now going to bring in the word trust, so that anyone who consults you or who you act in a professional way, they can rely on what you're saying. (P2, Law, Policy acted on)*

Participants explicitly linked professionalism to trust – that within the current conceptualisation of their professions, to be trustworthy was to behave in a way that allowed you to be accountable and answerable for your actions. Professionals understood that their actions were under scrutiny, and that they must be able to demonstrate that these actions upheld and were within the accepted norms of their profession: that actions were professional, and adhered to norms of 'professionalism'.

Within their accounts, participants revealed that they understood this norm of 'demonstrable accountability' to be linked directly to the expectations of the patient, client and/or public. This was also seen as reflected in the norms of the regulator – that by performing actions that were demonstrably accountable to the expectations of the client or patient, a professional could also demonstrate their accountability to profession/peers and regulator:

*Interviewer: whose trust would you say it's more important to have as a professional? Do you think it would be the public or your clients' or your patients' or regulators'?*

*P2, Law, policy acted on: Well both, but for me the ultimate is the client and the patient, yeah yeah yeah. Yes. Because if you've got that and you've acted in a trustworthy manner you ought to be able to show your regulator that what you did was right.*

Participants typically responded in this way noting that the individual patient/client was who they felt professionally accountable to. This accountability empowers the patient/client from the perspective of the professional who is providing the service, as patients/clients are, in some ways, given the power to determine what is, and is not, acceptable professional behaviour. It also empowers the regulator as a conduit for these expectations. Participants identified problematic aspects with this need for demonstrable accountability at the individual level, to broker imbalances in client's or patient's expectations:

*There is something about meeting people's expectations, and that's a tricky one - or ideally exceeding them, but um - it's tricky because you have to work out what the expectations are. But you know that's part of the job of professionalism and recognising that is very different for some people. Some of my patients are disappointed if I don't use some bad language, and others would be horrified you know - so that sort of thing (P28, Medicine, policy maker)*

This tension was particularly felt if client or patient expectations fell out with the norms of what professional is considered to be 'good practice', and/or the guidance to them given by their regulator:

*So you don't always go with what the client wants just because the client asks for it. I mean presumably the patients who want the antibiotics and you shouldn't be prescribing them where the doctor has to you know explain why he is going to prescribe the antibiotics and not do so just because the patient wants it - that doesn't mean it's right. But there are other situations that are not like that where I think if there's a conflict I would go with the patient, client. (P2, Law, policy acted on)*

Despite these concerns, participants strongly accepted that 'accountability' was key to their conceptualisation of 'being a professional'. Above all, this accountability was to the expectations of the patient or client, in line with those of the profession and regulator. Combined with the understanding that professionals provide a service (4.4.1), we can thus conceptualise the working 'reality' for professionals' to be that they must demonstrate how they have provided the customer the service that customers expect, in a rigorous and satisfactory way.

## Chapter 5: Discussion

The professions of Medicine and Law hold a moral contract to advance social welfare and social justice within modern society. Public trust in the professions is socially embedded, often unquestioned and generally seen as vitally important. In this project, we draw the concept of ‘trust’ out of this assumed realm, and investigate it under the spotlight. In doing so, we offer an innovative and timely exploration of the concept of ‘trust’ in the professions: critically questioning how this concept relates to ideas of professionalism and regulation; and exploring what it means to be ‘trustworthy’ within these professions.

The project draws on a comprehensive review of the literature concerning trust in the professions, including an investigation of public scandals and governmental inquiries into events that might have influenced the levels of public trust in the professions. It also draws on interviews with a purposeful, stratified group of thirty participants, to gain an overview of how professionals currently conceptualise ‘trust’ within their profession. Participants included active legal and medical practitioners, those creating and implementing policy, as well as public representatives (see Tables 1 and 2).

This chapter will draw together the findings of the literature review and the analysis of the interviews with participants. In the following sections, we summarise the findings in relation to our research objectives and thereby ‘answer’ our research questions. We then consider the methodological strengths and limitations of the research, and end the report with a concluding statement of key messages.

### 5.1 The impact of socio-political events

This project’s first objective was to critically explore the historical socio-political events that have impacted on perceptions of professionalism and the role of regulation in relation to trust in Law and Medicine. This objective aimed to create a better understanding of the historicity of current ideas and beliefs about ‘trust’ and how this socio-cultural context relates to ‘professionalism’ and ‘regulation’, through the literature review and interviews with participants.

The following research question refined and guided our investigations:

- What are the significant socio-political events that have impacted upon perceptions of professionalism and approaches to regulation in Law and Medicine?

Modern professions sit within the socio-cultural context of neoliberalism. This ideology follows, and is a reaction to, previous periods of classicism and collectivism. Within all these periods there have been substantial shifts in the ‘ways of thinking’ about professionals and the professions. For Law and Medicine, one of the most striking of these was the creation of Legal Aid and the NHS during the period of collectivism, which positioned professionals as working in the service of society, rather than as primarily prestigious private practitioners (as in the previous period of liberalism).

The current neoliberal period sits in opposition to the principles of collectivism, and argues that society should not be structured on ideological principles, but rather on empirical and evidence-

based policy making. It strongly promotes market principles within all areas, including the professions, and stresses the rights and priorities of the individual. The marketization of the professions has been accompanied with a shift to managerialism, in which targets, performance reviews, and strict regulation of professional activity are justified within an understanding of the need for measurable evidence for the continuation of service within the market. This is a substantial break from the self-regulation of the profession in the previous periods of collectivism and liberalism; and is supported and promoted by the state.

In the UK, legal provision is currently predominately a private and for-profit service. The literature argues that the expansion of neoliberal markets has routinized and deprofessionalized the profession, and centralized services. In this system, institutional and regulatory control has been increased, with self-regulation becoming increasingly formalised and structured.

In contrast, the vast majority of current-day UK medical provision still functions within the state-run (collectivist) model of the NHS. This now operates, however, under a system of New Public Management (NPM) which applies private sector management to the public sector. NPM requires workers to comply with measures demonstrating their 'efficiency', 'accountability', 'transparency', and 'quality'. Although this management model has been widely criticized for being unable to actually ensure these qualities are upheld (see e.g. Lorenz 2012 and Martin et al. 2013), it holds large sway over the operation of the profession and the requirements of professionals within it.

Increased scrutiny of professionals, from their regulators and the public – on whose behalf the regulators work – has been evidenced in high-profile media coverage of malpractice scandals (documented in Tables 3 and 4). These high-profile events are used to further argue for an increase of formal and compulsory regulatory mechanisms (Hazgui et al. 2015; Burrage 1996). The introduction of Revalidation for medical professions is one such example of this process (Archer et al. 2013). The socio-political context thus positions the professions as not only responsible for maintaining trust in the professions, but also dependent on a so-called 'trust-industry' – organisations that regulate and 'award' trust to 'good' professionals.

Although the literature set the socio-cultural and political context for our study, and informed us of how these ideas and beliefs may have come to be, it was not possible to find evidence of the impact of specific socio-political events on the professions (p.45). An in-depth discussion of the impact of particular events on the trust in the professions and/or professionals is a substantial gap in the literature. This gap highlights the originality of our approach, whereby we sought the perspectives of those currently working within, or allied to, the professions of Law and Medicine, in relation to this topic.

In both professions, our participants showed an awareness that the actions of individual professionals could damage the trust in the overall profession. High-profile events of malpractice were cited to justify this belief - within both professions but predominantly events within Medicine. Professionals at the centre of these scandals were labelled 'bad professionals' and disassociated from the majority of 'good professionals'. This created a strongly individualistic attitude: that each professional is themselves the object of scrutiny, and individually responsible for upholding the values of modern professions (efficiency, transparency, quality, accountability).



There was, however, a difference between how participants seemed to respond to a history of high-profile events within their professions. These responses were strongly embedded within the differing socio-political context of their profession:

In Law, participants told of fewer high-profile events within the profession, and attributed these predominantly to Lawyers committing financial malpractice at the expense of their clients. These examples of high-profile events were widely condemned, but were not seen to be of substantial detriment of the profession's image. Legal professionals believed that the public already had low levels of trust in the profession and its motives - considering public perception of the profession to be, at its worst, self-serving and financially exploitative. Associated, as they were, with lower levels of public trust in the profession as a whole, participants reported that scandals did little more than to reinforce the image of professionals already held – as financially self-interested. High-profile events thus contributed to the gradual and on-going erosion of trust in the profession, but not through radical reactions to the events themselves.

In contrast, participants from the medical profession referenced both a greater number and range of public scandals. This stronger reaction to high-profile malpractice events was justified in relation to the comparative vulnerability of the client/patient and the greater risks at stake in Medicine than in Law (a loss of life, rather than a financial loss). Medical participants were vocal about the need for rigorous regulation to proactively weed out malpracticing individuals - 'bad professionals' – so that they did no harm to patients.

Moreover, although some of this concern was linked to the perception of higher risk to patients, it was also linked to scandals' perceived risk to the overall trust and image of Medicine. Medical participants much more commonly referenced their regulator's role within scandals, citing the benefits of adhering to regulation to prevent scandals (beautiful promises) and warning of the threats to both the individual professional, and the profession as a whole, if regulation was not complied with (horrible promises). The dire consequences of the loss of trust in the individual medical professional, as well as in the profession as a whole, were likewise vividly painted through horrible promises: the public shunning preventative medicine, resurgence of disease and overall poorer public health.

Unlike Law, Medicine was considered by participants to be seen by the public as an inherently trustworthy profession. This was primarily founded on the perception that the public saw Medicine as a publically owned/run, not-for-profit service, in which the professionals worked for altruistic motives in the best interests of the patient. Participants noted that this perception was strongly embedded in the public consciousness. They even reported surprise at the enduring trust in the profession, and medical professionals, despite challenges such as high-profile events. They linked the robustness in public trust to the public's perception that doctors still always worked in the best interests of patients and the public and thus understood that these were rogue and occasional events (malpractice) or in the patients' long-term interest (strikes).

As a result of this altruistic image, medical participants appeared more anxious than legal professional about any potential loss of trust in the profession as a whole. In turn, this anxiety created additional pressure to determine themselves as 'good professionals' in order to maintain trust.

We suggest that participants have accepted that they must be seen as altruistic individuals and ‘good professionals’ in order to maintain trust – tied to the collective model of providing a service to the public. This also formed a strong part of their professional identity. Simultaneously, they have accepted the ideals of NPM – that each individual is responsible for maintaining their image as a high-quality, transparent, efficient and accountable professional to maintain the image of the profession as a whole. Within the evidence-based model of neo-liberalism, these qualities must be demonstrable and evidenced to be valid, and the individual professional therefore requires the regulator to ‘evidence’ that they are a ‘good professional’ and providing a ‘good service’.

In the neoliberal model, the balance of power is tipped towards the service users (customers) as they are empowered to scrutinise and criticise their service providers (the profession and individuals within it). The regulator acts on the public’s behalf – collecting, interpreting and defining ‘professionalism’ (discussed in detail below) – as well as enforcing these principles through scrutiny, guidance and disciplinary procedures. The regulator thus also draws power by empowering discourses and practices that promote the customers’ interests. Meanwhile, the professionals themselves also call for scrutiny, fearing that the consequences for the individual and collective could be dire without a regulator evidencing their ‘professionalism’.

The tension of the private-sector expectations of NPM, enforced and perpetuated by a strict regulator, in order to maintain a public-sector image of altruism were tangible within medical participants’ accounts. High profile events thus seemed to raise medical participants’ awareness of how much there was to lose, should these reduce public trust in the altruism of the profession.

In contrast, legal professionals’ accounts revealed no such anxiety, or pressure on participants to ‘prove themselves’ to maintain an image of the profession. They accepted that their services were transactional and worked to the expectations of the market, and as long as they provided these services in a trustworthy and transparent manner, no additional image-management was expected of them.

In this way, we can see how socio-political events and cultural and ideological context has substantially impacted ideas of trust, professionalism and regulation in the modern professions. High-profile events are just one part of this context. A number of events were cited more frequently than others, and those in Medicine were typically referenced more commonly than those in Law. Moreover, some events were understood to have precipitated changes such as increased regulation, especially within Medicine. However participants did not perceive that any one event had radically shaped the professions in a new direction. Rather, it seemed that high-profile events had further reinforced their acceptance of neoliberalist values (e.g. transparency, individual accountability and responsibility, increased regulation) within their practice.

## 5.2 Trustworthy attitudes, values and behaviours

Our second objective was to explore which attitudes, values and behaviours were understood to be required by the modern professional to maintain trust in the current context. In doing so, we aimed to unpick and interrogate what was meant by the term ‘trust’ in relation to professionals and, in so doing, explore how this understanding came to be and was sustained.

Investigations were guided by two research questions:

- How do perceptions of professionalism and approaches to regulation impact on conceptualisations of trust in these professions?
- What impact do these conceptualisations of trust have on the behaviours of associated professionals?

These questions sought to help us understand more about the interplay between trust and participants' perceptions of professionalism and regulation of the professions. The first of these questions drew on the findings of the literature review and the interviews with our participant group; the second question drew only on the interviews.

### 5.2.1 The impact of professionalism and regulation on public trust

In a neo-liberal context, 'professionalization' is understood to be a process by which producers of specialist services strive to build and control a market for their expertise. Professionals within this context must manage competition, strive for efficiency and arrange audit and accountability regimes that are imposed on the profession by the neo-liberal state. It is thus intertwined closely with regulation. We looked to the policy documents of regulatory and professional bodies in search of the definition of 'professionalism' – what it means 'to be or act as a professional'. This was, however, not clearly defined for either profession. The source of this definition (e.g. who decided the contents and delimited the boundaries) differed, however, in a marked way between the professions.

Within Medicine, the regulator reported professionalism as a set of behaviours: to be knowledgeable, safe, trusted, to communicate well and to be a good professional (GMC 2019). Although the term a 'good professional' is not precisely defined, it is clear that it is closely related to trust – that to be professional is to be trusted and vice versa. Other guidance also portrays this as closely linked to behaviour - to accomplish professionalism, doctors must act in accordance to the changing expectations of the patient and public. For example, 'Good Medical Practice' (GMC 2019) states that doctors must: listen to patients, give understandable information and respect patients' rights. These public expectations are reflected in the expectations of the regulator, who makes decisions about the parameters of 'professionalism' on the public's behalf – assessing the presence (or lack) of these behaviours and deciding on the (in)adequacy of these. Professionalism in Medicine is thus defined by public expectation, and trust predicated on this condition being met. Finally, the regulator is shown to enforce repercussions on professionals who fail to meet these behavioural standards, in order to maintain standards of professionalism and levels of trust.

Within Law, the policy documents cite 'professionalism' as behaving in a way that is likely to maintain trust and confidence of the public, and that this is a core duty (BSBH 2019; SRAH 2018). These documents do not specify how one must behave to meet this core duty however. Similarly, it is claimed that clients must believe that their professional does not intend harm, but there is no clear indication how professionals should behave to achieve this belief. The key contrast to Medicine appears when it is suggested that these behaviours are not specified by the public, but instead are defined by professionals themselves: "every person has their own value set and makes their decisions accordingly" (SRAH 2018). The assumption is thus, that if the professional deems the behaviour trustworthy, the client and regulator will too.

What does this mean in practice? In our participants' accounts we looked for how their perception of 'professionalism' impacted their ideas of trust in themselves as professionals and in their wider profession.

Participants reported that professional behaviour was essential to creating a trust-relationship with a client or patient. Difficulties, inefficiency and a lack of satisfaction for both client/patient (service user) and professional (service provider) were threatened if professionalism did not sustain trust. This professionalism was seen to be subjective – something to be tailored to each individual client/patient as needed to meet their expectations. Importantly within this, participants saw it as essential for their professionalism to convey to their patients/clients that they had their best interests as the highest priority and would not abuse their position or do their patient/client harm. For Medicine, this was seen to be important to maintain the public belief in the altruistic intentions of the profession (see section 5.1). For legal professionals, working in a neoliberal market, preserving trust in their good intentions was seen to be essential to maintaining and attracting clients, as well as adding to the satisfaction the professional found in the role.

As discussed above, our literature review revealed that the perception, or threat, of public mistrust in the professions reinforced the existence of regulation: the responsibility to uphold trust is individualised to each professional, and the regulator is tasked with ensuring all professionals are trustworthy. This is emphasised by the perceived vulnerability of patients/clients, who must rely on professions when at their most vulnerable (exposed to health or legal problems). However, as the patient/client cannot judge the competence of the professional – lacking the medical or legal expertise to solve their problems themselves – the regulator acts on their behalf, to ensure competence and good intentions to the client/patient. The hegemonic power of regulators to determine who enters and remains in the profession creates the premise that, without external regulation, the profession is bound to fail to act in a trustworthy way, and in the best interests of their vulnerable public.

Participants' accounts broadly reinforced this perception. Although they reported that the self-regulation of the professions was important and widely used, professionals at all levels and in a wide range of roles, argued that regulation was a necessary addition to self-regulation. This was justified from the point of view of the public, who they accepted would never see self-regulation as legitimate or effective. The need for external regulation, even if just to reassure the public, was thus presented as necessary.

Within both professions, participants cited the benefits of increased regulation to increase public trust (beautiful promises). In tandem, their accounts threatened that professional systems would not function without regulation to maintain essential trust within the professions (horrible promises). For Law, trust was threatened to be lost in professionals' ability to maintain their professional integrity in a self-interested, neoliberal marketplace (e.g. not financially exploit clients). Within Medicine, an unregulated profession threatened to allow the few 'bad professionals' the opportunity to abuse vulnerable patients, however, perhaps more importantly, it threatened that even the 'good professionals' would lose their ability to 'keep up with' patient expectations (and thus the parameters of professionalism). In this way, the medical regulator was seen to be necessary to aid 'good professionals' from slipping into unprofessional ways, not just to punish those who did.

Overall, these promises and threats were thus used to reinforce the necessity of the regulator as a guardian of trust in the profession, as these positioned regulation as inherently tied to maintaining trust within the professions.

## 5.2.2 The impact of trust on professional behaviour

Through our participants' accounts, we have seen how 'trust' is intertwined with ideas of demonstrable professionalism, and evidencing this through regulation. Looking in more detail, we can also explore how these conceptualisations also impacted their everyday practice and behaviour.

Our key finding, which was not well described in the literature, was that participants recognised that, although scandals might rock the trust in the profession as a whole, trust in the individual professional could be almost totally disassociated with this. This understanding of trust as an individualistic quality - established through relationships between individuals – meant that participants perceived it as still possible to maintain trust within their own practice, even if trust in the wider profession was challenged (e.g. the anti-vaccine movement in Medicine, or the perception of 'ambulance chasers' in Law). This was vital, as it was understood that trust in the overall professions was increasingly challenged and that, once lost, trust was extremely difficult to rebuild.

Trust was thus conceived to dwell within professional relationships – primarily between the practitioner and their client and patient. Two main components were seen as crucial to achieve client/patient trust: Firstly it was understood as crucial to demonstrate competence; and secondly, to convey that the client's/patient's interests were the professional's key concern. Associated 'professional' behaviours involved listening to client/patient needs and involving them in decisions. Maintaining transparency and honesty were seen as key to demonstrating competency. To demonstrate the seriousness in which they took their clients' issues, participants reported reflecting an earnestness in their professional behaviours such as formal speech, smart dress and certain expected rituals.

Participants highly valued this trust, seeing it as fundamental to the functioning of their 'service' and the satisfaction of both client/patient and practitioner. Accordingly, the highly valued identity of a 'good professional' was characterised as someone who could create and maintain trust in professional relationships.

Participants reinforced these values and identities through reference to the negative consequences (horrific promises) of losing trust in their relationships with clients/patients. In a non-trusting relationship, the service was portrayed to be substantially more difficult to provide effectively. In this sense trust was mechanistic for professionals, as it achieved a more pleasant and efficient work experience. Moreover, it was shown to be a failure of the professional (service provider) to be unable to produce something their patient/client (service user) was 'entitled to' (see quote by P22, p.62). 'Bad professionals' who had broken or abused the trust of their clients and patients were held up as examples who were rightfully punished by the regulator (see 5.1).

We therefore suggest that establishing trust through professional relationships can be considered a 'protective force' for individual professionals, as well as a facilitator to effective practice. Both these reasons encouraged participants to prioritise behaviours which underpinned 'trust' in them as a professional.

### 5.3 Implications and future research

Our third research objective considered the broader social implications of the current conceptualisation of trust, which has come to be accepted as ‘reality’ across the professions. This required us to explore what our findings might ‘mean’ for current practice and policy, as well as future research within the legal and medical professions.

Thus exploration was predicated on the *problem-driven* approach, which is fundamental to the logics approach to analysis. This pushes researchers to reveal the ‘taken-for-granted’ structures, assumptions and ‘rules’ that underpin a particular ‘reality’, and examine, critique and challenge these (see p.19 for a fuller explanation). In doing so, we aim to break with current patterns of thinking, encourage criticality and question: ‘what might be possible instead?’ This opens up an ideological ‘space’, and new viewpoints, from which readers are able to consider change.

The approach is, however, not a *problem-solving* approach: it does not look to ‘solve’ specific issues within the current structures, but to take a ‘big picture’ view to open up new ‘ways of thinking’.

The following research question thus focussed our inquiries:

- What are the implications of the research and areas for future development?

#### 5.3.1 Social implications of this concept of ‘trust’

Comparing and contrasting Law and Medicine throughout this research has highlighted the similarities and differences between the professional structures, beliefs and practices within each profession. For example, in Medicine, there was a perception that trust could be *given immediately* to medical professionals, as they were perceived as altruistic and working in a ‘no fee at the point of service’ environment. This was in striking contrast to the perceived requirement of legal professionals to *build* trust in professional relationships, due to their participation in a neoliberal, for-profit marketplace.

Our research highlights the marked difference in the level of public trust in a profession in relation to its status as a public or private enterprise. Moreover, it evidences how these conceptualisations of trust have tangible and empirical effects on practitioner, client and patient behaviour. For example, current ‘ways of thinking’ about trust, separated concept the ideas of 1) trust in professionals as an individualistic quality, primarily between service provider and service user and; 2) trust in the profession as a whole. This ‘protected’ the individual practitioner, as trust in them could be maintained, even as public trust in ‘the professions’ as a whole was diminishing and constantly under scrutiny and challenge. Within this pattern of thinking, the worth of public trust was largely seen as desirable but not essential, because patients/clients had ‘no choice’ but to rely on professionals in times of vulnerability and need (which they could still do, as they could still trust in their individual practitioner).

This position reinforces current neoliberal structures of ‘trust as individualistic’ and able to survive within neoliberal marketplaces. However, this may be a ‘blinkered’ view which unquestioningly accepts the current ‘reality’ as the only one possible and legitimate. Indeed, some participants challenged this view, with predictions of wide-scale disruption if public trust was lost in the inherent role of the professions to uphold and further social welfare and social justice. Examples given include: the rise of the anti-vaccine movement and conspiracy theories; resurgence of disease and poor public

health; a reluctance to seek or follow professional advice; social unrest, lawlessness and disruption. Policy makers should be aware of these social implications, and factor these into decisions about the future of the professions – both in the UK and internationally.

Professionals too should critically consider the impact of neoliberal structures and associated conceptualisations of ‘trust’ on their professions, and everyday practice. The individualistic conceptualisation of trust may be protective for ‘good professionals’ who are buffered from wider challenges to the image of the professions as a whole and can continue to forge trust relationships with patients and clients unhampered. However, for medical professionals particularly, this concept is predicated on a need to ‘evidence’ that one is a ‘good professional’ through intensive and continual regulation. This creates an increasing dependency on the growing ‘trust-industry’ of regulatory bodies and systems. Although this ‘reality’ is strongly reified, it is not unchangeable. Although Medicine functions within a different context and under an increased perception of risk, increasingly strong regulation is not the only possible response – just one of many. In this project we have exposed the ‘logics’ and ‘ways of thinking’ that have brought about the current situation and structures, and which work to reinforce these as assumed and unquestioned. With these understandings revealed, we encourage audiences to consider how these might be different, and improvements changes might bring.

Finally, it is interesting to note the persistent and determined legitimacy of the idea of ‘trust’ within participants’ accounts. This was seen as key to their professional lives, despite substantial changes to the everyday workings of their professions, due to technological changes, service demands and cultural changes. For example, despite the growth in the knowledge economy, the neoliberal requirements for evidence-based practice and push for specialised knowledge in both Medicine and Law, trust was still perceived to be of strong social importance in professional relationships. Moreover, these personal relationships were still seen as key to patients’/clients’ decision to meaningfully engage with professional advice and the norms and institutional values of the professionals more generally. This highlights the strong social implications trust has in modern professions.

### 5.3.2. Areas for future research

The comparative approach (between Medicine and Law) greatly aided analysis and helped bring unexpected findings to light. These two well-established and prestigious professions shared key commonalities in relation to conceptualisations of ‘trust’, as well as marked differences. Future research into trust, professionalism and regulation should utilise this comparative approach. Comparisons between the ‘newer’ professions (e.g. Nursing, Engineering, Piloting etc.) and the ‘traditional’ professions (e.g. Law, Teaching, Medicine etc.) would be particularly interesting. Likewise international comparisons of the same profession across differing contexts may illuminate context-specific differences.

We spoke to those working with the professions at various levels (policy makers, policy enactors and practitioners/policy enacted on), as well as two ‘lay’ representatives who did not belong directly to the profession, but were connected to it in meaningful and informed capacity - considered the ‘beneficiaries’ of policy (See Table 1). This gave us a well-rounded view of ideas of ‘trust’ within the

professions – that of the ‘service providers’. It would however, be interesting for further research to investigate ‘trust’ in the professions from the lay perspective – the point of view of the ‘service user’, (clients and patients). This might reveal interesting and useful comparisons to understand both how ‘trust’ is understood to be ‘received’ and built from this viewpoint.

Our findings showed that currently trust in the UK legal and medical professions is crucial at the level of the individual relationship between practitioner and client/patient. This has endured despite technological and cultural changes. It would, however, be interesting to consider the impact of future, and potentially very ‘disruptive’ technologies on ideas of trust and this trust relationship. For example, as automated forms of legal practice and health advice advance and are increasing accessible online we could question whether public and professional concepts of the importance of trust, and the role of the practitioner within this, may shift. These potentially disruptive technologies include e-health and tele-medicine, robotics in surgery, as well as artificial intelligence (AI) and machine learning. Moreover, we could question whether disruptive technologies may challenge the power structures and processes of regulation within the professions - for example Blockchain may have the potential to allow professionals to own and update their own registration details, allowing systems to become much more contemporary, accountable and verifiable.

#### 5.4 Methodological Strengths and Limitations

Readers will note that only three of the four categories of social actor are represented in the legal profession sample, and that the distribution of participants across the categories is different than planned (see Tables 1 and 2). We found it especially challenging to recruit participants from the legal profession – particularly those who fell into the ‘policy makers’ and ‘policy enactors’ categories. Towards the end of the data collection period, the research team therefore decided, that it would be best to meet the overall quota of 15 legal professionals, irrespective of what category they were classed within. This decision resulted in the full 15 participants from the legal professions being recruited. Moreover, this participant group still contained individuals from a large variety of roles and levels of seniority in the legal profession. For example, although the group were predominantly practitioners (with policy being ‘acted on’ them), their experience levels and roles varied from trainee to senior partner. The legal profession is also very diverse, and this group included solicitors and barristers working across areas such as corporate, commercial, employment and criminal Law.

Participants were all professional people with connections to prestigious professions (Medicine and Law). As a result, we did not expect there to be a power imbalance between interviewer and interviewee, or that this might bias participant responses. Before and during interview, we specifically encouraged participants to give their personal perspective (rather than an institutional one). This was because intuitional views had already been gathered from the policy documents examined in the literature review, which we now wished to compare with the personal experiences and beliefs of professionals ‘on the ground’ who were experiencing this policy within their practice. Measures to elicit a personal view included ensuring participants were aware that their data would be stored confidentially, and that total anonymity would be guaranteed in any publications. The interview guide was also designed to elicit personal views (see Appendix 1). However, it is still possible that some participants discussed their institutional perspective, rather than a purely personal one – and that these would often overlap.



Trust across different professions varies widely (IPSOS MORI, 2018). Although this report focusses on Law and Medicine, trust in these professions does not exist in isolation and instead is interlinked and influenced by wider attitudes about other professions as well as the particular situation at hand. Working in large, multidisciplinary teams and networks, trust in legal and medical professionals may be conflated with the levels of trust in, for example, the police or nursing. Moreover, the circumstances in which they meet clients and patients, will influence levels of trust: e.g. a routine appointment vs a critical operation; a high-value purchase vs a criminal trial. The level of power imbalance and risk of harm in each interaction is therefore individually calibrated and should be assessed in relation to its multifaceted context. This report supplies substantial detail and data in the form of quotes to assist and encourage the reader to understand this context and make their own critical decisions about the credibility of findings in each instance.

Within the logics approach, the researcher is considered to be an integral and subjective part of the research process, who will inevitably create unique decisions and interpretations of the data (Miles et al. 2013; Glynos et al. 2009). This is, in part, an advantage of the methodology, as researchers may bring their own strengths and experiences to the work, allowing them to identify and challenge subtleties and complexities that might be missed by more positivistic or deductive approaches (Anderson 2010). This must, however, also be recognised as a challenge as it may create bias within the research. Therefore, within this project, we have taken several steps to improve the dependability (and thus the trustworthiness) of the work. These include: a detailed description of the methods is included so that the analytical process could be dependably retraced and justified; lengthy examples from the data combined with rich description allow readers to make informed judgements about the credible of the findings and study conclusions; and the ongoing critical conversations and varied perspectives of the research team aided reflexivity and critically throughout the duration of project (see e.g. Willig (2001) and Miles et al. (2013)).

The nature of this project means that it is highly context specific, rooted both spatially and geographically, and having taken place in one point in time. As such, results are not generalizable or directly applicable to other contexts. The strong thematic similarities in participant views across UK locations, and the rigorous application of theory increases the usefulness and transferability of the findings however (Reeves et al. 2008). The 'Logics approach' to analysis (Glynos et al. 2009) allowed us to not only build a detailed understanding 'what' legal and medical professionals currently understood to be their 'reality' of practice, but to also open these 'realities' up to critique. We were thus able to explore and explain 'how' and 'why' these views had come to be formed, by investigating the logics (beliefs and reasons) which underpinned, supported and challenged these. The strongly theory-driven approach to this project offered a highly relevant and effective approach to answering our research questions, and allowed us to contribute original and innovative findings to the field. Moreover, it also anchored this work within a well-established theory and advances this to a new field. Future studies may consider using this methodological approach to further our understanding about other concepts within the professions, or in other fields.

## 5.5 Concluding statement

Overall this research offers a significant contribution to our current understandings of the conceptualisation, and subsequent impact, of current ideas about trust, professionalism and regulation in the professions of Medicine and Law.

Our review of the literature on this topic revealed little was previously known about the impact of high-profile events and scandals on trust in the professions, a gap which this research sought to fill through in-depth interviews with professionals and those allied to the profession (policy makers, policy enactors, practitioners and lay representatives). We found that participants did not perceive that any one event had radically reoriented or challenged the current structures of trust within the professions. Instead we suggest these events worked to reinforce participants' acceptance of the neoliberal contexts and management systems in which they worked.

Participants understood trust in their profession to consist of two separate elements: 1) trust between the individual professional and their patient/client and; 2) trust in the profession as a collective. This understanding of trust as two specific concepts, and the implications of this for practice, are not well described in the literature. We suggest that the perception of trust as an individualistic quality meant that participants perceived it as very possible to maintain trust within their own practice, even if trust in the wider profession was challenged. The subsequent prioritisation of this individualistic aspect of trust, maintains the neoliberal structure of the professions as transactional service providers. Moreover, we suggest that this neoliberal structure was, in turn, supported by professionals who saw it as a 'protective force' for individual professionals, in the face of ever greater public scrutiny and expectations of their professions as a whole.

Finally, we reveal how the individualistic concept of trust may also perpetuate and increase regulation in the medical profession. This conceptualisation of trust is underpinned by the claim that each professional is individually responsible for upholding the values of modern professionalism (e.g. efficiency, transparency, quality, accountability) in order to uphold public trust in themselves, and the profession as a whole. As the neoliberal model calls for this professionalism to be evidence-based, the regulator is empowered to show that it enforces these principles to the public through scrutiny, guidance and disciplinary procedures. Trust in the altruistic image of the medical profession is highly valued in the system and high-profile events are seen as (one of) the threats to losing this. As a result, although at times they found the level of regulation oppressive, medical professionals themselves accepted and even encouraged increased scrutiny, fearing that the consequences for the individual and collective could be dire without a regulator evidencing their 'professionalism'.

In contrast, legal participants' accounts conveyed that they neither experienced, nor felt the need for such strict regulation. This is an interesting difference between two otherwise comparable - traditional, well established and prestigious - professions. We suggest that these differences may stem from differences in context: legal professionals predominantly work within a neoliberal and for-profit marketplace; whereas medical professionals work predominantly within a public, not-for-profit system (the NHS) which relies on the support of the tax-payer and an altruistic image, but must nonetheless also meet the expectations of the marketplace (efficiency, transparency, accountability).

This report purposefully identifies and exposes the processes and tensions inherent within conceptualisations of trust, and interrogates how these ideas came to be, and continue to be reinforced in everyday practice. In doing so, it encourages audiences to question the taken-for-granted

assumptions about the formation and maintenance of trust in Medicine and Law and to see these as temporal and constructed. This opens up a critical space in which we encourage audiences to view the neoliberal structures that define professionalism, empower regulation and distribute trust to be only *one possible* way of organising the professions (instead of the one accepted 'reality'). We challenge audiences to question, how might things be different, and what improvements might this bring?

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## Tables

Table 1. Description of social actor types and target quotas

Actor Type	Description	Target number		Total target per actor type
		Medical professionals	Legal Professionals	
Policy makers	Individuals involved in <i>creating</i> social or organisational policy relating to the topics of 'trust', 'regulation', and/or 'professionalism.	5	5	10
Policy enactors	Individuals involved in <i>implementing</i> social or organisational policy relating to the topics of 'trust', 'regulation', and/or 'professionalism.	4	4	8
Policy acted on (professionals)	Individuals <i>impacted by</i> social or organisational policy relating to the topics of 'trust', 'regulation', and/or 'professionalism.	5	5	10
Policy acted on behalf of (public)	Individuals understood to benefit from social or organisational policy relating to the topics of 'trust', 'regulation', and/or 'professionalism.	1	1	2
Subtotal		15	15	
Total		30		

Table 2. Participant Group

Actor Type	Medical professionals	Legal Professionals	Total (per Actor Type)
Policy makers	5	0	4
Policy enactors	4	1	5
Policy acted on (professionals)	5	13	18
Policy acted on behalf of (public)	1	1	2
Total (per profession)	15	15	
Total participants	30		

Table 3. Timeline of recent potential significant events in medicine

Year	Event
1969	Report of the committee of inquiry into allegations of ill-treatment of patients and other irregularities at the Ely Hospital
1978	Normansfield Hospital
1984	The report of the committee of inquiry into an outbreak of food poisoning at Stanley Royd Hospital
1999	Ashworth High Security Hospital
2000	Rodney Ledward Inquiry
2001	The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995
2001	Royal Liverpool Children's inquiry report (Alderhay)
2004	Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling
2005	Neale inquiry
2005	The Shipman inquiry
2010	The Kerr/Haslam inquiry
2013	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
2013	Review of the Response of Heart of England NHS Foundation Trust to Concerns about Mr Ian Paterson's Surgical Practice; Lessons to be Learned; and Recommendations
2014	The Vale of Leven Hospitals Inquiry
2015	Winterbourne view inquiry
2015	The Report of the Morecambe Bay Investigation
2018	Independent review into the issues raised by Paterson
2018	Infected blood inquiry
2018	Gosport War Memorial Hospital The Report of the Gosport Independent Panel
2019	The inquiry into Hyponatraemia-related Deaths
2019	Independent review into Gross Negligence Manslaughter in Healthcare

**Table 4. Recent public inquiries**

<b>Year</b>	<b>Event</b>
1848	The Lynskey tribunal
1967	Report on the Aberfan disaster inquiry
1972	The Widgery tribunal
1973	Report on the Lane Inquiry
1990	Report on the Piper Alpha disaster public inquiry
1993	Report on the May inquiry
1996	Report on the Shootings at Dunblane Primary School public inquiry
2001	Report on the Bristol inquiry
2002	Report on the Shipman inquiry
2000	Report on the Ladbroke Grove Rail inquiry
2003	Report on the Laming inquiry
2004	Report on the Hutton inquiry
2004	Report on the Fraser inquiry
2004	The Robert Hamill inquiry
2010	Report on the Bloody Sunday inquiry
2011	Report on the Rosemary Nelson inquiry
2012	Report on the Levenson inquiry
2008	Report on the ICL (joint) inquiry
2009	The Fingerprint inquiry
2009	Report on the Outbreak of E. coli O157 in South Wales public inquiry
2014	Report on the Al-Sweady inquiry
2016	Report on the Iraq inquiry
2017	The Grenfell Tower Fire inquiry

## Appendix 1: Topic Guide for Interviews

- 1) So I'd just like to start today with you telling me a little about yourself
  - a) How did you come to be [job role]
  - b) Could you just talk me through any previous professional experience of trust/professionalism/regulation in [profession] that you might have?
  
- 2) TRUST
  - a) Generally speaking, how would you define the word "trust"?
    - i) What does the word "trust" mean to you?
    - ii) Can you describe what a trustful person is?
    - iii) Think of the person you trust most in the world; how have you come to trust them so much?
    - iv) Is 'trust' an absolute, or a scale?
  - b) Are you a trustworthy person?
    - i) How do you know this?
    - ii) Do you ever have to demonstrate this?
  
- 3) PROFESSIONALISM
  - a) What does the word "professionalism" mean to you?
    - i) How can 'professionalism' be demonstrated?
    - ii) How important is it to demonstrate 'professionalism' do you think?
  - b) How would you define "trust" in relation to a [professional]?
    - i) Can you describe a trustworthy [professional]?
    - ii) How important is it to be trusted as a [[professional]?
  - c) Do you feel members of the public trust their [professional]?
  - d) Broadly speaking, do you think the [profession] as a whole is trusted?
    - i) Do you feel the public trust the [profession]?
    - ii) Is there anything unique to this idea of trust [profession]?
  - e) Do you think there have been any key events that have impacted on trust in the [profession]?
    - i) What about any high profile events that attracted lots of media attention?
  
- 4) REGULATION
  - a) How do you feel about the regulation of the [profession]?
    - i) What would you say is its purpose?
    - ii) Is it necessary? [*challenge and response*]
  - b) Do you feel regulators and policy makers trust [professionals]?
    - i) What about the [profession] more generally?
  - c) What impact do you think the regulation of the medical profession has on the trust of it?
    - i) Do you think regulation increases/decreases trust in [professionals]?
    - ii) What about the [profession] as a whole?
    - iii) Who's trust does it increase/decrease?
      - (1) Public?
      - (2) Patients?

- (3) Policy makers?
- (4) Regulators?
- d) Whose trust is most important, do you think – the public's or patients, or regulators & policy makers?

- 5) Is there anything important that we've not spoken about today, that you think we should have?**
- 6) Is there anything that you wish to add or clarify? [THANK AND CLOSE].**