THE UNIVERSITY *of* LIVERPOOL

Control of doctors in the NHS: a critical appraisal

Thesis submitted in accordance with the requirements of the
University of Liverpool for the degree of Doctor in Philosophy

by

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October 2010

ABSTRACT

This thesis is a study of different UK governments' initiatives in attempting to control the medical performance of doctors in the NHS in England between 1979 and 2008, in order to enhance patient safety, improve healthcare delivery and improve cost-effectiveness. The study focused on control mechanisms in the NHS's clinical governance structures to illustrate the relationship and tensions between professional autonomy of doctors and management. Appraisal of NHS doctors is being used as an exemplar of one control mechanism and its tensions when set against self-regulation and bureaucratic control. The aim of this research is determine to what extent the government is able to control the clinical performance of doctors in the NHS through appraisal. The importance of the topic was identified as public policy concerns over such issues as poor healthcare quality standards, inequitable distribution of services, lack of consumer responsiveness, inefficiencies and loss of control of escalating expenditure, and public accountability of the medical profession.

The research methodology is partly based on an extensive review of government health reform initiatives from 1983 to 2008, focusing on the UK State's efforts to increase control over the medical profession and to more closely monitor clinical performance. It is also partly based on empirical data from surveys and interviews aimed to explore the use of appraisal leading to revalidation (ALR) as a control mechanism within the NHS and analyse doctors' views and responses to the introduction of professional performance monitoring in healthcare. Survey and interview data contributed to the assessment of the extent to which appraisal is being used as a control mechanism by the government and the processes which could prevent it becoming an effective control mechanism.

A tentative framework towards a new governance structure has been proposed. This intends to offer a new avenue to reduce the tensions around multiple accountabilities between government and medical professionals, especially to parliament and to patients. The complexity and areas of duplication in the existing system should be reduced. The framework might reduce the identified institutional dissonances and be more responsive to external environmental changes without the need to restructure, which has been the usual response up to now where complexity is met by yet more complexity. Also, a policy implication is offered to suggest the future of appraisals in the NHS.

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ACKNOWLEDGMENTS

It has been a long and difficult journey to accomplished this thesis. I would like to express my sincere gratitude to those who made this thesis possible, especially my supervisor Dr. Frank Worthington, with his genuine warmth, encouragement, sympathy and support when I was in academic and personal difficulties. Thanks are also due to my earlier supervisor Prof. Denis Smith, who guided me during my early study.

I wish to express my heartfelt thanks to my close friends: Dr. David Kirkham; Dr. Florence, Chong; Dr. Lisa, Liu and all my follow research colleagues in the Management School – we share a history and vision that nurtures and delights me.

Special thanks are extended to many academic and administrative staff at the Management School, for their help, support and friendship over these years and hopefully over the years to come.

My special appreciation goes to my parents, my sisters, and my in-laws for their constant support and encouragement. And last but definitely not least, I wish to express my deepest gratitude to my mother, who helped me to take care of my little child, and whose strength and support inspired me to complete this study. Second, to my husband for his love, help and support, and to my little girl, who lights up my life. She had to stay away in China, in order for me to complete my study. I am indebted to her.

Finally, I wish to acknowledge myself and the will that it took to keep on going through re-write after re-re-write, long after I thought I had finished.

I dedicate this thesis to my mother – Ms Wang YuShu, my husband Jason Smith and my daughter Lilly-Amber, as a symbol of my endless gratitude. Thank you for putting up with both the study and me for so long and for ensuring that I persevered to the end.

GLOSSARY

CCG: Consultant Career Grade
CHI: The Commission for Health Improvement
CMO: Chief Medical Officer
CQC: Care Quality Commission
CRHP: Counsel for the Regulation of Healthcare Professionals
CHRE: Council for Healthcare Regulatory Excellence
DoH: Department of Health
DHA: District Health Authority
FHSA: Family Health Service Authority
GCC: General Chiropractic Council
GDC: General Dental Council
GMC: General Medical Council
GOC: General Optical Council
GOsC: General Osteopathic Council
GP: General Practice
GSCC: General Social Care Council
HPA: Health Protection Agency
HPC: Health Professions Council
HQIP: Healthcare Quality Improvement Partnership
ICAS: Independent Complaints Advocacy Services
MORI: Market and Opinion Research International
NCAA: National Clinical Assessment Authority
NCAPOP: National Clinical Audit and Patient Outcomes Programme
NCAS: National Clinical Assessment Service
NCCG: Non-Consultant Career Grade
NHS: National Health Service
NHSE: NHS Executive
NMC: Nursing and Midwifery Council
NPSA: National Patient Safety Agency.
NQB: National Quality Board
NICE: National Institute for Clinical Excellence
RHA: Regional Health Authority
RPSGB: Royal Pharmaceutical Society of Great Britain
SAS: Staff and Associate Specialist
SpHA: Special Health Authority

DECLARATION

I hereby declared that I am the author of this thesis. I take all responsibility of any mistaken interpretations of the data.

Chapter 1

CONTROL OF DOCTORS IN THE NHS: A CRITICAL APPRAISAL

"The heavier a stone, the faster it falls" (Aristotle 384-332)

1.1 Introduction

This thesis is a study of UK government-driven attempts to control the clinical performance of doctors in the NHS in England in order to improve patient safety and health care delivery. It deals with the long-standing question of control and accountability of doctors within the health service that has always been an issue for the State, and examines the changing dynamics of the professional autonomy of doctors in light of the calls for the reform and regulation of medical practices, as illustrated in the appraisal discourse. "Doctors remain 'professionals' but the traditional image of what this means in practice – a selfless clinician, motivated by a strong ethos of service, equipped with unique skills and knowledge, in control of their work and practising all hours to restore full health to 'his' or 'her' patients– is increasingly outdated" (Rosen & Dewar, 2004: 1).

It concentrates mainly but not exclusively on consultant and non-consultant career grade NHS doctors. The main focus of this research is to examine the introduction of policies designed to more closely regulate the medical profession, concentrating in particular on the role that the introduction of appraisal leading to revalidation (hereafter - ALR) is intended to play in this process. The aim of ALR is to monitor doctors' performance by rendering them more accountable to management, government and patients in terms of the use of resources in order to improve service delivery, patient choice, patient care, and safety.

The challenge faced in this study is to understand the relative influence of government policy reforms in shaping organisational control mechanisms in the NHS, relative to healthcare service delivery, and to demonstrate that this publicly-funded institution is "acting on collectively valued purposes in a proper and adequate manner" (Townley, 1997: 264). The role of appraisal in these reforms may be seen by doctors as a Foucauldian panoptic control method designed to govern their day-to-day activities and part of a struggle between professional power, derived from their specialised knowledge, and management's desire for greater control of performance for the common good. This power of expertise

"can be used as a powerful justification for resistance to change" (Worthington, *et al.*, 2006: 1).

1.2 The issues behind this study and their importance

This section explores the issues which are to be addressed in this study and seeks to explain why they are of considerable importance to healthcare in England. The NHS has always been a political issue (Grint & College, 1993) and so the drivers for change and the consequent initiatives of Conservative and Labour governments between 1979 and 2008 are central to the context of this study. The complex factors precipitating the need for change in healthcare by government have been the subject of much research in recent years (Kleine & New, 1988; Strong & Robinson, 1990; Barach & Small, 2000a).

Within the United Kingdom, the public policy makers were grappling with problems that ranged from a lack of equity, poor quality of healthcare and loss of control over costs of health provision, the lack of responsiveness to consumers, inefficiency in service provision, and the tradeoffs between these objectives (Griffiths, 1983; Enthoven, 1985, 1988). These issues are not confined to the UK, as debates over healthcare in the US (Rodwin, 2001) in New Zealand (Upton, 1991) and in *Seven European Nations* (Hurst, 1991) have demonstrated.

A key issue was the perceived low standards of medical quality in the NHS, which has been the subject of substantial study (Rosenthal, 1995; Smith, 1998a, 1998b; Stacey, 1992; Longley, 1992; Dingwall & Fenn, 1992). In addition, public awareness of patient safety in the UK has increased rapidly. This is due in part to the numerous official inquiries into medical malpractice and their attendant publicity in the media. There have been inquiries into failures of care by individual clinicians; homicides by medical professionals, for example, Harold Shipman (Smith, 2004); at Alder Hey Hospital the retention of human organs (Redfern, 2000); and failures in paediatric hospital procedures at Bristol Royal Infirmary (Kennedy, 2001).

This last case was seen as a landmark for addressing deficiencies of professional regulation. Such a series of adverse events have caused serious negative publicity, which has resulted in the questioning of professional self-regulation in the NHS and have added weight to calls for reform. It may be that government has taken advantage of the public criticisms of, and the apparent crisis in, the NHS as part of its justification for the agenda for State intervention to achieve more effective State control and regulation over doctors that has been beyond its reach throughout the history of the NHS. In terms of improving efficiency,

the reforms also reflect the government's search to establish more accountability from, and control over doctors. However, the key political themes of Labour reform in the NHS are focussed on quality, safety, accountability and efficiency (DoH, 1999: *Clinical governance: quality in the new NHS*). The government showed a strong concern for the development of clinical governance in order to prevent failures.

Under Labour, medical malpractice, healthcare quality, patient safety and self-regulation became central issues that needed to be addressed. This then focussed on changing the regulation of health professionals. "Such changes do not come about without political struggles. In this fight, physicians traditionally possessed significant clout: their authority based on medical expertise. Doctors decided what was medically appropriate with little need to explain or justify their decisions" (Rodwin, 2001: 440). Thus a major theme of this thesis is the struggle over control of medical performance between successive governments and the medical profession.

In some initiatives, the struggle was more covert as in the introduction of clinical governance though evidence-based medicine. "But the political issues are still there, even when they are addressed indirectly using the language of technique and evidence....Under these circumstances, evidence becomes an instrument of politics rather than a substitute for it" (Rodwin, 2001: 442). Other initiatives were more overt, for example the measurement of clinical effectiveness and appraisal.

The NHS has experienced many significant political shifts since its inception, with financial and organisational changes and alterations in policies. The later emergence in the NHS of multiple political interests, caused by conflicts within the health profession and changing public perceptions has led to a government mentality of frequent policy shifts. *The NHS Plan*: A Summary (DoH, 2000: 2) points out that "the NHS is a 1940s system operating in a 21st Century world" with its pressure between primary care and hospitals, the "rigid institutional barriers" between local health services and social services, and between the public and the private sectors.

Furthermore, there is "over centralisation between central government and the NHS [which] has veered between command-and-control and market fragmentation" (DoH, 2000: 30: Para: 2.13). This is compounded by the fact that the various organisations that provide the multiple functional services integrate with different cultures, under various management agendas and deal with a range of different problems. All of this is undertaken in the context of a high-profile political landscape of endless intervention and unendurable pressures from

the public and the government. In other words, the health services are not just based on social needs, technical development and professional interests, but are also dominated by the government's exercise of its power, and it is this which seems to preoccupy NHS reforms today.

This exercise of power has at times been directed towards doctors. Since for centuries doctors have had autonomy, "but there was little in the way of external assessment or control over medical practice outside of informal professional self-regulation. These conditions promoted physician autonomy and sovereignty" (Rodwin, 2001: 440). One mechanism for providing this external assessment of medical practice was the introduction of appraisal linked to revalidation, underpinned by political and ideological stances and driven by public disquiet over high profile adverse events.

For doctors who have been through intensive reforms since the 1980s, appraisal might perhaps be interpreted as just one of many management initiatives after the internal market, clinical audit and clinical governance. The doctors have built up a form of resilience to the government interventions. However, doctors' concerns might be more acute if appraisal inevitably leads to a process of revalidation of the licence to practice. This might create political pressures between doctors and the government, leading to a compromise on revalidation as "part of a progressive development" which was considered by van Zwanenbery (2004: 386) as "part of a complex political readjustment between the main stakeholders" for the regulation of doctors.

This study is important because the context in which self-regulation is located seems to have changed in several ways, necessitating reforms. "This is a critical time for the future of the medical profession, with unprecedented challenges arising from the changing expectations of patients, government and managers" (Rosen & Dewar, 2004: 1). The use of appraisal as a means of controlling medical performance has fundamental implications for professional autonomy 'for medical practice, including preventing malpractice, and may exemplify wider changes in modes of NHS management" (McGivern & Ferlie, 2007: 1361).

First, it has been argued in the literature (Thornley, 1998; Mannion & Davies, 2002) that there is a crisis in healthcare such as: the problem of severe nurse shortages (Finlayson, *et al.*, 2002; Rogers, *et al.*, 2004); bed shortages (Kendrick, *et al.*; 1997; Kinton, 2007); some cases of patients with serious injuries denied care (Johnson & Woolf (2007); and a funding crisis in the NHS now "having a knock-on effect on social care for the elderly and disabled"

(BBC News, 2006). This has generated far greater public awareness than ever before around the NHS.

Secondly, "the emergence of an information revolution, which both diminishes the apparent omniscience of the doctor and also gives patients a greater understanding of their own condition as well as of the performance of the professional who is treating them" (Levenson *et al.*, 2008: vii). Thirdly, there are expanded roles for doctors, as for example clinical directors, new technologies and different working methods involving multi-disciplinary teams. Fourthly, the medical profession itself is more receptive now to the need for changes in professional autonomy. The traditional image of a doctor as "a selfless clinician, motivated by a strong ethos of service, equipped with unique skills and knowledge, in control of their work and practising all hours to restore full health to 'his' or 'her' patients - is increasingly outdated" (Rosen & Dewar, 2004: 1). A King's Fund study *Understanding Doctors* found that many doctors recognized "that they needed to find ways - in every corner of their profession – to enable greater flexibility in working patterns [which] required a move from individual responsibility to a professional responsibility for the system of care" (Levenson *et al.*, 2008: 63).

Finally, there appears to be a lack of empirical evidence around performance appraisal and its impacts on professional medical autonomy (Chamberlain, 2010). This study is an attempt to rectify this supposed deficiency by reporting on doctors' own experiences and perspectives on appraisal linked to the revalidation of the licence to practice. This may well have policy implications on the nature of future regulatory regimes for the medical profession.

A major initiative in reforming professional regulation is the government introduced appraisal leading to revalidation. So, the purposes of this study are: to contribute to the debate on the response of hospital doctors to this policy initiative; and to examine the utility of the government imposed performance appraisal as a tool for closer control and monitoring of doctors' performance standards.

1.3 Research aim and objectives

The control of the performance of doctors has progressively become a major political issue in the NHS for government in respect of quality, cost effectiveness, patient safety and accountability. The framework in this thesis is multifaceted and based around theories of control. This was because no participant observation was possible and also because control

theories have been well studied by numerous scholars as having explanatory power when tracing the struggle for control between the State and the medical professional over three decades of NHS reforms.

The review of the literature on the intensifying pressures from the State to increase control over professional autonomy to monitor clinical performance alludes to a long history of struggle around the control of doctors. The outcomes of the reforms demonstrate a shifting balance between markets, hierarchies and networks (clans) in the NHS. The changes in the delivery of public services, informed by the Conservative ideology of New Public Management, as shown for example by the newly created role of clinical director, has sometimes actually extended the power of doctors within the NHS, as an unintended consequence.

The literature intends to highlight some limitations that exist in previous studies that have investigated these issues. Also, the literature served the purpose of providing some qualitative evidence to answer the research questions. Doctors were largely viewed, in much of the literature, as an homogeneous entity, regardless of the reality of their diverse expertise, the complex and heterogeneous nature of the profession, occupational cultures and medical practices. Medical self-regulation juxtaposed against the external monitoring and control of the medical practices has led to control becoming increasingly fragmented for the State, especially after the Griffith's reforms.

This study is about control mechanisms in the NHS, with appraisal being used as example of one control mechanism. Appraisal in the reforms since the 1980s seems to be one mechanism for strengthening the State's challenge to professional self-regulation, in terms of increasing doctors' accountability and improving health service delivery. The study will explore the tensions when appraisal is set against professional autonomy and the medical cultures and evaluate the effectiveness of appraisal as a form of medical control as perceived by doctors.

In the literature, discussion of the potential control function of appraisals in the NHS is predominantly confined to topics related to experiences in other sectors, around human resource management and Foucauldian power and knowledge conflicts. These studies tend to treat doctors as a homogeneous group. However, more recent studies have given more recognition to heterogeneity in the NHS and this heterogeneity may account for the variety in the doctors' responses to appraisal. They clearly demonstrate that the doctors' responses

range between resistance and adoption in the light of its power-effect on their position and autonomy (McGivern & Ferlie, 2007).

So the aim of this research is to determine to what extent the government is able to control the clinical performance of doctors in the NHS through appraisal. If it is found that such control is likely to be ineffective, then other alternatives for control will be put forward and the alternative futures of appraisal will be explored. This fundamental research aim presupposes a range of research questions and underpinning research questions outlined in Fig. 1.1. The research follows three distinct, but inter-related strands. First, from the doctors' perspective; second from the government's perspective; and third using appraisal as an exemplar of a control mechanism. All three are set within the context of the long-standing struggle for control of the medical profession by government. However, in this struggle both parties are mutually dependent since, "The state needs the profession to implement policies which deal with the demands of its citizens, and the profession needs the state to continue to support its self-regulatory and market privileges" (Salter, 2003: 934).

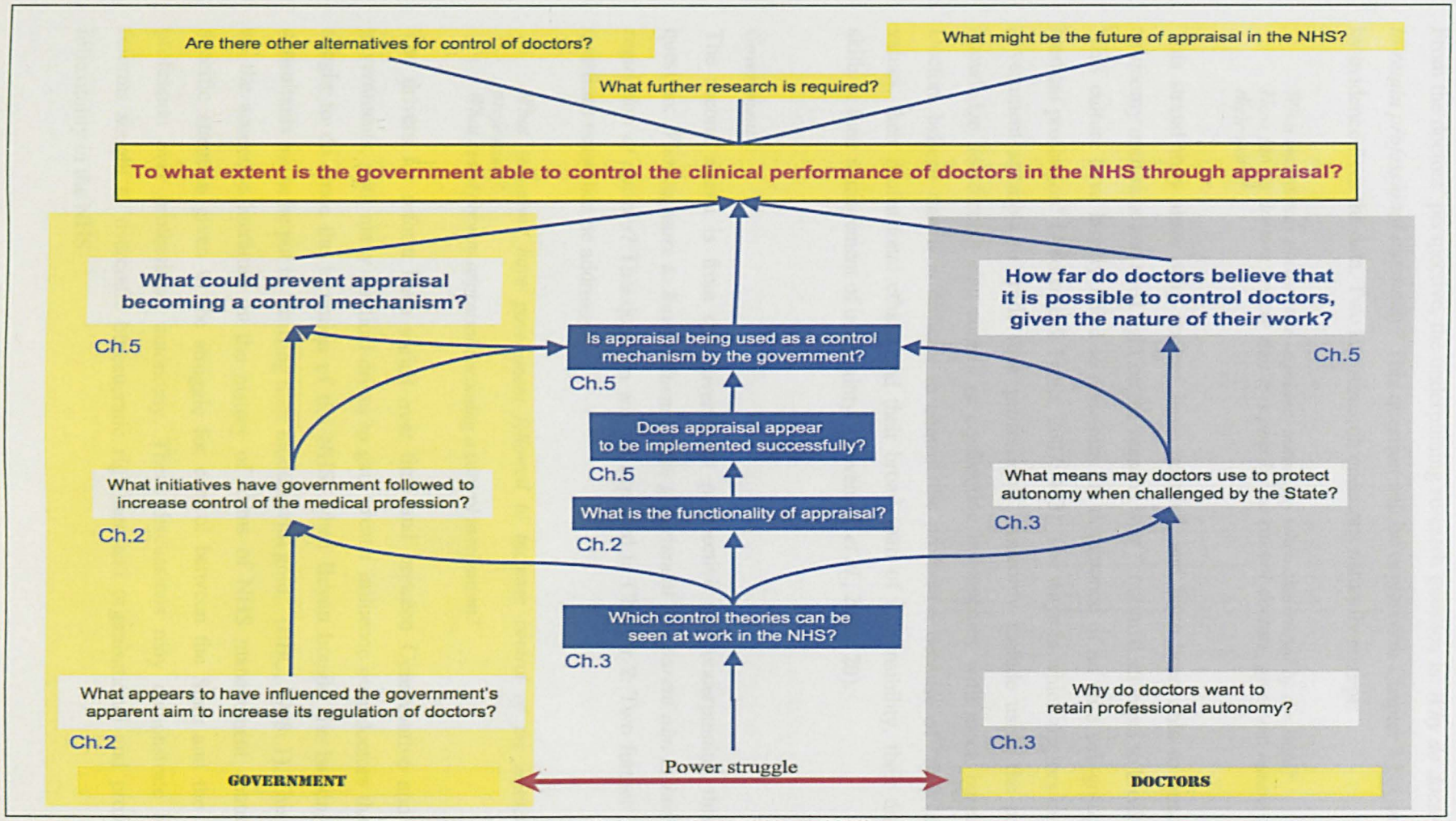

Fig. 1.1 The scope of the research (Format from Kirkham, 2009)

Doctors

From the doctors' perspective, the underpinning research question is: *Why do doctors want to retain professional autonomy?* This question will be explored in Chapter 3 but supported by evidence from the data. Two key research questions naturally emerge:

> *What means may doctors use to protect autonomy when challenged by the State?*
> *How far do doctors believe that it is possible to control doctors, given the nature of their work?*

This strand may show why doctors have guarded, and have been able to guard, their autonomy until now and shed light on the reasons why "continual attempts to break the old NHS culture have largely failed to penetrate the dominance of an elite sub-group of the medical profession" (Addicote & Ferlie, 2007: 403). The ways in which doctors may resist government attempts to erode their professional autonomy include using the power of knowledge, reinforcing clan control or confronting bureaucracy with mock bureaucracy. Doctors believe that it is difficult to control the profession because of "their altruistic values, their professional ethics, and their broad span of responsibility, their diagnostic skills or their management of uncertainty" (Levenson *et al.*, 2008: 20).

Government

The second strand is from the government perspective and underpinning this is the question: *What appears to have influenced the government's apparent aim to increase its regulation of doctors*? This question will be explored in Chapter 2. Two further research questions must then be addressed:

> *What initiatives have government followed to increase control of the medical profession?*
> *What could prevent appraisal becoming a control mechanism?*

The drivers for reform have varied over time and between Conservative and Labour governments, with many political drives to gain greater influence over doctors than it has sought to do since the inception of the NHS, when Bevan bought the backing of the consultants by, as he put it, "stuffing their mouths with gold" (BBC, 1998: 1). This focuses on the academic literature on the history of forms of NHS management control, with specific attention given to the struggle for control between the State and the medical profession over professional autonomy. These discussions may demonstrate how the reforms sought to overcome bureaucratic rigidities and organisational and professional inflexibility in the NHS.

Appraisal

The third strand uses appraisal as an exemplar of one control mechanism that may be employed by government and underpinning this is the underpinning research question: *Which control theories can be seen at work in the NHS?* This question will be the focus of Chapter 3. Three further research questions relate to appraisal:

> *Does appraisal appear to be implemented successfully?*
> *Is appraisal being used as a control mechanism by the government?*
> *What is the functionality of appraisal?*

There will be discussion around Friedman's (1987) distinction between responsible autonomy and direct control and Dent's (2005) argument that the government is looking to shift from a "tolerant professional autonomy" to a 'responsible' autonomy. Also Ouchi's (1979) organisational control theory will be explored as a possible framework for analysis. Townley's (1993b) adaptation of Foucault's concept of panoptic surveillance will be reviewed to assess its utility in determining the extent to which the State wishes to shift healthcare from a bureaucratic to a post-bureaucratic form of control.

It is necessary to evaluate whether appraisal is a positive tool for increasing the control and monitoring of professional performance to detect problems. An assessment will be made of how useful appraisal can be in improving health service delivery, efficiency and patient safety. Evidence will focus on looking at how the Consultant and Non-Consultant grades respond to appraisal and perceive it, both positively and negatively. It was said that revalidation of doctor's registration and the annual appraisal were "complementary professional and managerial functions" (Smith, 2004: 1033). But van Zwanenbery (2004) observed that appraisal and revalidation are part of "tightened bureaucratic control being applied to professional self regulation" (op. cit.: 686).

1.4 The structure of the thesis

The thesis contains seven chapters. This chapter has introduced the background to the study, the issues which it seeks to address and their significance and the aim of the research with the associated research questions.

Chapter 2 deals first with the factors influencing the need for NHS reforms and the consequent initiatives of the Conservative governments between 1979 and 1997. The government's restructuring of the public-sector reflected the rise of 'New Public Management' (Hood, 1991), which aimed to change public sector organisational structures

and cultures, improve the cost efficiency, give better value for money and improve quality of public services and, through these reforms, much greater government control and more accountability of the medical professions (McGivern, & Ferlie, 2000; Bolton, 2004; Dent, 2005). The initiatives are analysed under the headings of marketisation, consumerism, performance measurement, managerialism and structural reform. The new managerialism, along with the power-effect of the role of surveillance and regulation through mechanisms such as audit and inspection was a major challenge to the professions and their established autonomy (Power, 1999).

Chapter 2 continues with a review of the drivers for reform and the consequent initiatives of Labour governments from 1997 to 2008. Added weight for these reforms and for increasing external state regulation and control was provided by the public scandals, such as Shipman and Alder Hay (Dent 2003a), and media reporting of the inquiries resulting from these scandals. Under these pressures, the General Medical Council was compromised and faced the problem of repairing the damage in government and public confidence in the NHS. The medical profession itself had therefore no choice but to be cooperative with the government, otherwise this would have jeopardised their role and position in health care (Dent 2003b).

The Labour initiatives focussed on quality systems and patient safety, health improvement and control of health professionals, which illustrates how appraisal leading to revalidation plays its role in the State's struggle to establish greater accountability, transparency and closer control over the way doctors practice medicine. This review helps to illuminate the constant theme of struggle between professionals seeking to preserve their autonomous status, and government and managers seeking to control the work of doctors.

Chapter 3 deals with the struggle for control between the State and the medical profession over professional autonomy. It uses a force field analysis to explore the driving forces of the government to implement changes in the control of doctors through appraisal and the restraining forces that may seem to be used by doctors to resist their loss of professional autonomy. It seeks answers to underpinning research questions around why doctors want to retain professional autonomy and the means they may use to protect this autonomy when challenged by the State.

Also Chapter 3 explores the literature on control theories as they are applied to the NHS and links the reforms discussed in Chapter 2 to NHS control mechanisms. It reviews the sometimes inconclusive literature around the tensions between professional self-regulation

and direct control by (strengthened) NHS management as well as the shift to a 'responsible' autonomy (Friedman, 1987; Dent, 2005). It develops a broad analysis of organisational control based upon Ouchi's (1977) distinctions between bureaucratic, market and clan control, and on Townley's (1993) adaptation of Foucault's concept of panoptic surveillance. The study focuses on how doctors respond to government policies and the implications of the challenges to professional self-regulation and seeks to determine the extent to which the State wishes to shift healthcare from a bureaucratic to a post-bureaucratic organisation. These discussions demonstrate how the reforms since Griffiths (1983) have sought to overcome bureaucratic rigidities, and organisational and professional inflexibility in the NHS.

Chapter 4, on research methodology, will reflect on the problematic in this study and the rationale for the methods applied. It discusses some of the arguments and rationales for combining quantitative and qualitative methods. The methods adopted allowed the exploration, on a macro-level, of NHS control mechanisms and the tensions between doctors' autonomy and managerial control. At the micro-level, in researching the perceptions and concerns of individual doctors about how appraisal leading to revalidation could improve the control systems and improve health care, quantitative (questionnaire) and qualitative (interview) methods were used in tandem.

Chapter 5 will discuss and classify the empirical findings from semi-structured interview data and questionnaire survey data. It will address the functionality of appraisal, especially its formative functions, and the nature and quality of its implementation. It will then adduce evidence of appraisal being used summatively as a control mechanism by government and doctors' opinions on this theme. Data around the opinions of doctors on the extent that they believe that they can be controlled given the nature of the work that they perform. Finally, assessments will be made of the factors and considerations that may prevent appraisal linked to revalidation becoming an effective mechanism of control in the NHS.

Chapter 6 will discuss the findings in relation to the relevant concepts and theories of control in this study, and integrate these theories and practice to find how far the theories and data fit together. It will review some key similar studies on control of medical performance, in particular appraisal and revalidation also identifies the similarities and the differences in the findings. The chapter will answer the main research question about the extent to which the government can control the clinical performance of doctors through appraisal. Finally the chapter will identify the current governance structure in the NHS by using Mintzberg's five elements of organisational configuration and to evaluate its

limitations and disadvantages in the control of medical professionals. A new framework will be use as a conceptual tool in terms of promoting dialogue, and perhaps to reduce the institutional contradictions found in the current model.

Chapter 7 summarises the study, identifies the main conclusions and their implications for theory and practice. It provides a statement of the contributions of the research together with comments on its limitations. Finally it looks at future lines of research; reviews alternatives to appraisal linked to revalidation as a mean of the control of doctors' performance and contemplates the future of appraisal.

Chapter 2

INITIATIVES TO ASSERT GOVERNMENT CONTROL OF DOCTORS

"The NHS is intensely political." Enthoven (1991: 60)

"From its inception the NHS has been in an almost continuous state of reorganisation."

(Beachey, 2008: 2)

2.1 Introduction

The first chapter has identified the issues to be addressed and their importance, the background, the research questions and has provided the structure of this thesis. This chapter deals with the long-standing question of the control and accountability of doctors that for some public sector analysts and public policy theorists has always been an issue for the State. This chapter explores the academic literature on the evolution of government control of NHS doctors, with specific attention given to the struggle between the State and the medical profession over professional autonomy and *why* professional self-regulation became and remains such a pressing political issue in UK healthcare.

The chapter seeks answers first to an underpinning research question around the factors influencing the government's perceived need for NHS reforms. Both Conservative and Labour governments covered the period under review from 1979 to 2008. Several of these drivers seem to have had the apparent aim of increasing the regulation of doctors working in the NHS. The chapter secondly explores the initiatives that successive governments have followed and identifies those which, directly or indirectly, appear to increase their control of the medical profession. It also introduces the illustrative case of appraisal linked to revalidation and seeks to answer a research question around the functionality of appraisal.

The wide-ranging restructuring by the government of the public sector from 1979 was top-down pressure for change (Ashburner, *et al.*, 1996). A timeline (Fig. 2.1) sets the NHS reforms in their historical context. It orders chronologically the consultation documents, White Papers and key reports with the consequential legislation, and the responses of the profession. It also indicates the period when official inquiries investigated medical misbehaviour and malpractice, which may have accelerated the demands for greater control of the medical profession.

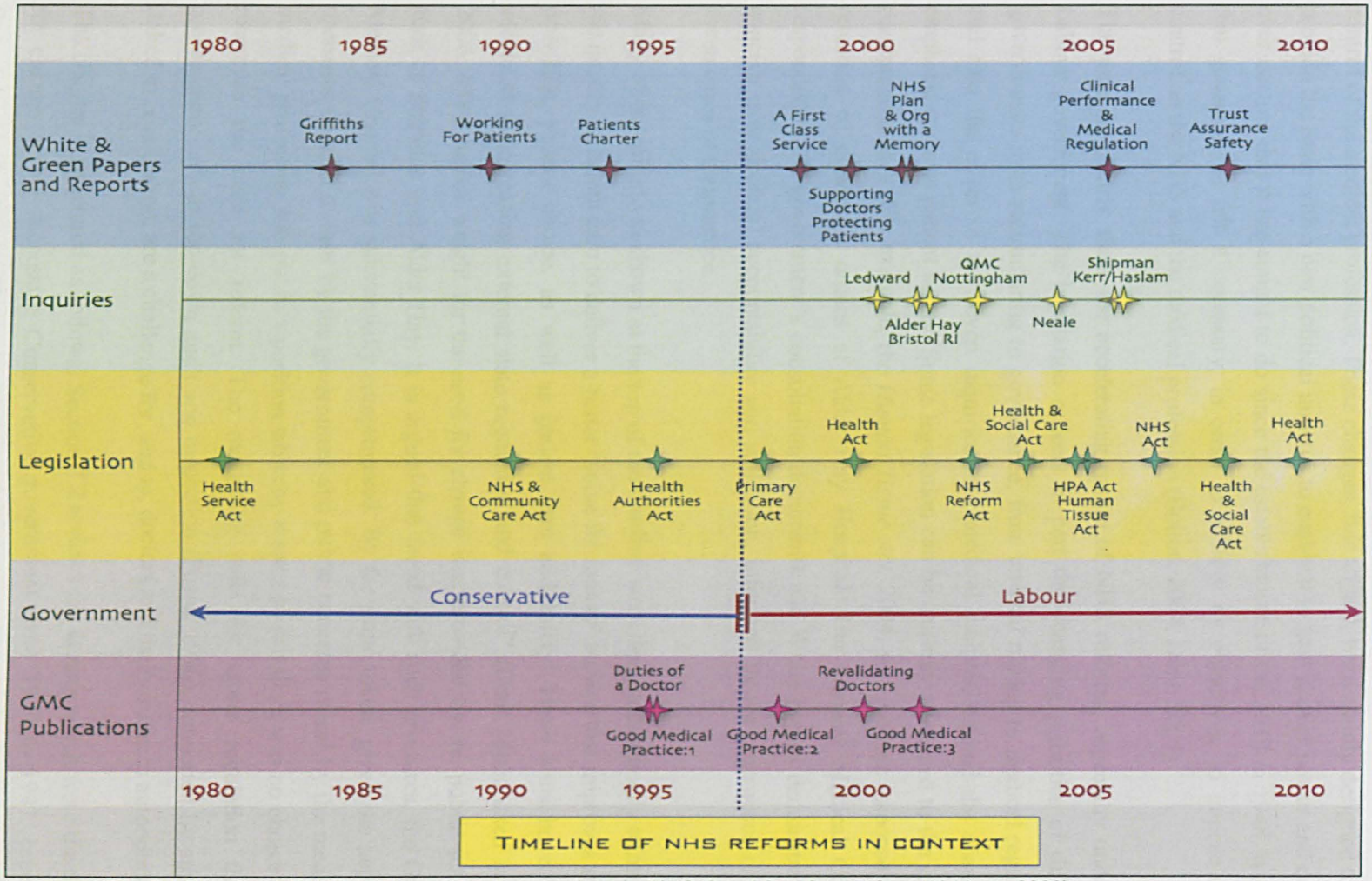

Fig. 2.1 Timeline of NHS Reforms (Sources are given in Fig 2. 3 and 2.5: format from Kirkham, 2009)

Against this backdrop will be a review of the literature around the evolution of government initiatives. In keeping with the key aims of this thesis, the chapter examines the changing dynamics of the professional autonomy of doctors and the emergence of the call for closer control of the medical profession. These changes, it is argued, were mainly designed to help provide the State with a new political impetus to enable it to gain greater power and control over doctors that it has sought to do since the establishment of the NHS in 1948. It seems that governments felt it necessary, in order to achieve its objectives, to impose closer control on the NHS and the medical profession (Bolton, 2004, Dent, 2005).

The timeline clearly show the accelerating nature of NHS reforms, especially under the Labour government. The legislation reflects in part the changing priorities of different governments from restructuring to governance, from internal market to medical regulation and also the effect of the seven inquiries into medical malpractice and the change of emphasis towards patient safety. Some legislation can be causally attributed to the inquiry recommendations. For example, the *Human Tissue Act,* 2004, was a direct response to the retention of children's organs at Alder Hay Hospital. The General Medical Council responded to the government's consultation documents and White Papers demonstrating a concern over doctors' accountability and validation, informed by the emergence of these seven cases of malpractice.

Many of the initiatives shown at the top of the timeline were designed radically to improve the quality of health care to deliver a better 'value for money' service that improves service provision, patient choice, as well as patient care and safety. These aims have "been subjected to increasing external state regulation and control" (Dent 2003a cited in Dent 2006: 458). Added weight for the need for change was provided by the public scandals, such as Shipman and Alder Hay. It is argued that faced with such pressures, the General Medical Council was substantially compromised. By the same token, given the need and pressures brought to bear by the government and public concerns raised by the media, the medical profession was put in a position whereby it seemed that there was no choice but to recognise the need for reform. The overriding calls for closer regulation through mechanisms such as top-down audit and inspection (Power 1996), supported by appraisal linked to revalidation, are a challenge for, and to, doctors and their claims to autonomy.

The chapter is structured as follows. Section 2.2 reviews the factors which were the drivers for change during successive Conservative government from 1979 to 1997, especially financial, organisational, efficiency, ideological issues. It continues by assessing the various government responses under the headings of marketisation, consumerism, performance

measurement, and managerialism and structural reform. Section 2.3 addresses the implications of these Conservative government initiatives on the control of doctors' performance.

Section 2.4 covers the drivers of Labour reforms including healthcare quality, medical malpractice, patient safety and self-regulation issues. It also analyses the responses to these drivers under the headings of health improvement, quality and patient safety and control of health professionals. Section 2.5 analyses the implications of these initiatives on the control of doctors' performance, especially appraisal linked to revalidation. Section 2.6 provides a conclusion to the chapter.

2.2 Drivers and initiatives of Conservative governments (1979 - 1997)

The Conservative Governments of 1979, 1983, 1987 and 1992 oversaw what proved to be, and to some extent remain, fundamental and controversial reforms of the National Health Service (BBC News, 1999; Hunter, 1996; Jessop, 1993; Klein, 1995, 1998b; Mays & Keen, 1998; Paton, 1995, 1997). The key drivers for reforms of the NHS under the Conservatives may be categorised under the headings of financial, organisational, efficiency and ideological issues (Fig. 2.2). The control and regulation of doctors were not central to the reforms but were included in the factors and in the subsequent initiatives. As a result of the influence of these factors identified by Griffiths (1983) and Enthoven (1985, 1988, 1991) in the 1980s, the government's health policies "signalled the beginning of a more market-driven and management-dominated approach to the NHS" (Hutton, 1994; Davidson, 1993; NHS Management Executive, NHS Made Easy, 1992; cited in Burnes & Salauroo, 1995: 15).

Key Drivers for Change

The wide-ranging restructuring by the government of the public sector from 1979 "was the continuing experience of top down (indeed government sponsored) pressure for change in both public and private-sector organisations" (Ashburner, *et al.*, 1996: 1). Although in the NHS the issues are arbitrarily divided into four components, they are actually inter-related in a complex mosaic.

Financial Issues

In 1979, when the Conservatives came to power, it was under fiscal pressure internally from public sector systems of welfare provision. Externally, it faced economic crises resulting from the oil shocks, global recession and the legacy from the previous Labour

government. In response to these pressures the Government's key political agenda was to reduce the tax burden and size of the public sector. This resulted, it is argued, in "a degree of ideologically based suspicion toward the NHS and a reduction in commitment to the [established traditional government commitment to the] founding principle of the service" (Greener, 2001: 636).

Organisational Issues

The 1979 Thatcher administration supported the NHS, but at the same time argued that its management was weak and was therefore ineffective as a vehicle for driving through reform. The government, influenced by Griffiths, "blamed inefficient management and structures within the NHS for the problems facing the organisation" (Beachey, 2008:1).

The NHS management structure was rigid and over-centralised, inefficient, riddled with perverse incentives and as a result was a serious obstacle to change (Enthoven, 1985; 1991). And there were "too many tiers that made decision-making slow and had led to a waste of resources."(Glynn & Perkins; 1998: 258). Also, Griffiths "was critical of consensus management, and saw the lack of a clearly defined general management function" at that time "as a key weakness in the NHS" (Smith & Ham, 2000:3). More specifically he argued:

> *"NHS had no coherent system of management at a local level. It lacked any real continuous evaluation of its performance against normal business criteria: levels of service; quality of product; operating within budgets; cost improvement; productivity; motivating and rewarding staff; research and development." (Griffiths, 1983: 10)*

Efficiency Issues

The Conservatives, during this period, were concerned with efficiency and cost control (Hunter, 1995; Klein, 2000) as well as the waste of resources identified above. The reform agenda was driven by the need to "minimise costs and maximise efficient provision of services" (Firelbeck, 1996: 529; Greener, 2004; Klein, 1995, Powell, 1996). It was seen that there was a need to improve service delivery, increase the efficiency and accountability of clinicians and deliver value for money. This had implications for all parts of the public sector, in which the NHS was a particular target and therefore certainly not immune (Kennedy, 2001; Para, 27).

Performance measurement was not a significant concern within the NHS at that time. As Griffiths identified (1983: 10), "Precise objectives for management were rarely set and there was little measurement of health outcomes. There was little evaluation of clinical practice and even less evaluation of the effectiveness of clinical interventions."

Ideological Issues

The government was driven by ideologies of neo-liberalism, 'New Public Management' and a consumer focus. Its economic ends of reducing the cost of the State, especially the perceived need for increased NHS budgets, had to be reconciled with its political aims. The Conservatives had "very different assumptions about the welfare state compared with those of their labour predecessors" (Greener, 2001: 637). The climate of neo-liberal values of efficiency, individual responsibility and market choice would obscure the original ideals of equitable health access and consumer choice as the guiding principles of the NHS. Frielbeck (1996: 529) argues that the "broader economic climate and political constraints have directly influenced the change in the provision of health care."

'New Public Management' (NPM) is a "slippery concept", open to a wide range of interpretations by different scholars and it is now "a somewhat dated label" (Manning, 2001: 297). From one perspective it means reducing the role of the State (Polidano, 1998), seen as undemocratic, unresponsive, rigid and inefficient, by means of privatisation, contracting out and public finance initiatives, and importing private sector management ideas for running the remaining public services. Other perspectives emphasize the centrality of the citizen or customer, and accountability for performance, by providing incentives lacking in the old bureaucracies (Batley, 1999). Yet another perspective sees NPM as a mechanism for improving efficiency, by separating policy from operations and by using market logic (Gow & Dufour, 2000), and responding to political imperatives. Osborne & Gaebler (1991) laid down ten principles of NPM. These included governments steering nor necessarily providing public services, which should be 'owned' by communities, with wide participation in decision making, and providing customer choice. They saw competition as inherently good, with government leveraging market forces and driven by aims rather than compliance with rules.

Informed by 'New Public Management', with its rhetoric that had at its core "the notion of empowerment, and the importation of consumerism and the 'market' to" solve the problems of managing public services (Dent, 2006: 449), the government created a major ideological shift in health provision. In their study of transformation in the NHS, Asburner, Ferlie & FitzGerald (1996: 14) observed "the gradual diffusion of ideas and models from the private sector, some carefully filtered out, others of which have undergone modification as they have been moved into the public sector." This diffusion has impacted the "relationship between the medical profession and the State and within the profession" (Day & Klein, 1992: 468).

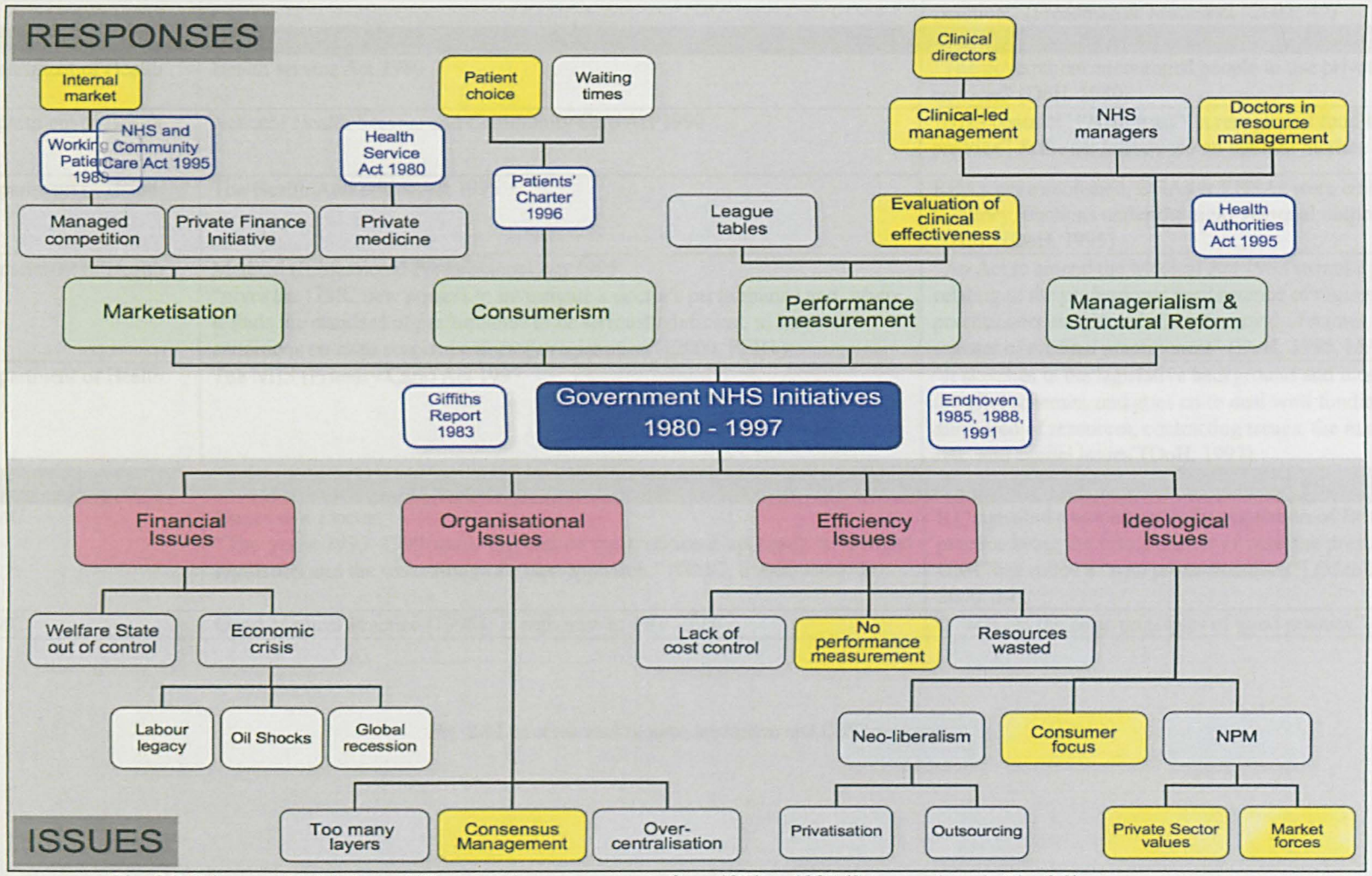

Fig. 2.2 Drivers and initiatives of Conservative governments from 1979 to 1997 (Sources given in Fig. 2.3)

YEAR	AUTHOR(S)	PUBLICATION	COMMENT
WHITE PAPERS, REPORTS AND CONSULTATION DOCUMENTS			
	Griffiths, R.	NHS Management Inquiry (1983)	It introduction the notion of the general management
1989	Department of Health	Working for Patients	"It required all doctors to adopt medical audit in their clinical practice". (Freedman & Macaskill, 2002: 47)
LEGISLATION			
1980	Department of Health	Health service Act 1980	"The government encouraged people to use private medical services" (DoH, 1980)
1990	Department of Health	National Health Service and Community Care Act 1990	"NHS contract" "NHS trust" "a recognized fund-holding practice" & the act introduced an internal market. (DoH, 1990).
1995	Department of Health	The Health Authorities Act 1995	RHAs were abolished, DHAs & FHSAs were emerged. Their statutory functions under the eight 'regional outposts' of the NHSE. (DoH, 1995)
1995	Department of Health	Medical (Professional Performance) Act 1995 "gives the GMC new powers to investigate a doctor's performance and, where it finds the standard of performance to be seriously deficient, to impose conditions on or to suspend a doctor's registration" (2000, PFB1)	"An Act to amend the Medical Act 1983 to make provision relating to the professional performance of registered medical practitioners and the voluntary removal of names from the register of medical practitioners" (DoH, 1995, MA)
1997	Department of Health	The NHS (Primary Care) Act 1997	"It sketches in the legislative background and intended aims of the pilot schemes, and goes on to deal with funding issues, the allocation of resources, contracting issues, the management of risk, and capital issues"(DoH, 1997).
GMC PUBLICATIONS			
1995	GMC	Duties of a Doctor "The years 1995–1999 mark the end of the traditional approach to medical regulation and the welcoming of a new approach." (GMC, Irvine, 1995: 2).	It ["signalled a revolution in the regulation of British medical practice being the first indicator of what the president of the GMC has called a "new professionalism"] (McManus, *et al*, 2000: 14).
1995	GMC	Good Medical Practice (1995), it withdraw in July 1998	It "sets out the basic principles of good practice" (GMC, 1995).

Fig. 2.3 List of relevant reports, legislation and GMC responses

The major government responses

The government responses to these key drivers may be grouped under the four headings of marketisation, consumerism, performance measurement and managerialism with structural reforms (Fig. 2.2). Again, the control of doctors was not central to these initiatives but was a significant component of them. The Conservative government believed that privatisation was an alternative for overcoming economic rationing, with the market, competition, business and enterprise solving the problems (Powell, 1996; Iliffe & Munro, 2000). The ideas and recommendations of two advisors were very influential - Griffiths (1983) and Enthoven (1985, 1988, 1991).

The Griffiths Report promoted three main vehicles for reforming the NHS: efficiency drive, private finance and community care. The "central aim of the Griffiths reforms was to produce a more cost-effective NHS" (BBC News, 1999 September, 20). Smith & Ham (2000:3) indicated that, "The Griffiths Report proposed the immediate introduction of a general management structure at all levels in the NHS (regional, district and unit)," and the current government readily "accepted these recommendations" (ibid.). As a result, the existing system of 'consensus management' was replaced by a new system based upon 'general management' that was introduced in 1984. Thus it "represented a distinctly different approach to managing medical power and reflects a more critical attitude towards the power of management" (Dopson, 1994: 27).

Enthoven's (1985, 1988) theoretical and empirical work, giving an analysis of the functioning of the health care system from an economic perspective, informed the 1989 review of the NHS. The subsequent reforms were seen as "a further tightening of state control over NHS resources and ultimately clinical discretion, which, at the micro level, allocates resources" (North, *et al.*, 1999: 408). Enthoven saw the NHS "as an integrated organisation, in which district health authorities would employ general practitioners and they could contract out if they were unhappy with local services. He thought that the better thing would be purchaser competition" (House of Commons, 2009: 11).

Marketisation

Marketisation covered three main areas of the private finance initiative (PFI), the formal and partial integration of private medicine with the NHS and managed competition. The market principle applied in these reforms blurred the boundary between public and private forms, and the government clearly signalled the "acceptance of pluralism in health care" (Klein, 1995: 332).

The first health initiative of the new Thatcher government was the formal NHS recognition of private medical services under the *Health Services Act* (DoH, 1980). This led Burke *et al.* (cited in Sines *et al.*, 2009: 20) to suggest that one of the outcomes of such a policy led to the erosion of the "principle of a free health service at the point of use" and led to accusations of a two-tier service.

Within marketisation, outsourcing and the PFI were key components of the Conservative's agenda. The former "forced the NHS to put in-house services out to tender and award contracts to the lowest bidder" (BBC News, 1999, September, 20). The latter "brought in private firms or consortia that would put up the capital for major NHS projects. Private firms could pay for the design, construction and operation of buildings and support services" (ibid.). To support and promote this new system the jurisdiction of *Health Service Commissioners* (Office of Public Sector Information, 1996) was also extended to monitor hospitals' PFI policy and performance.

Perhaps the government response that was to have the greatest impact on the struggle for control between the State and doctors was the concept of managed competition. The concept was proposed by Enthoven, building on the foundations in the Griffiths Report. Enthoven's approaches to understanding the health care system stemmed primarily from an economic viewpoint: cost/benefit ratios, incentives and other market-driven values needed to create a more cost-efficient system that could be closely monitored and which is open to change. His concept of an internal market system of control was intended to address the problems of NHS management and instil into the new system economic incentives that, he argued, the NHS lacked (Enthoven, 1991: 60).

The White Paper *Working for Patients* (DoH, 1989) shows Enthoven's influence on NHS reorganisation. It has been seen as a Thatcher government "response to a funding crisis" in the NHS (Elkind, 1998: 1716). These proposed reforms to the NHS were based upon the principle of managed, in other words internal, competition. *The National Health Service and Community Care Act* (1990) was the means of their implementation. Thus, an internal market was created in April 1991 through internal competition in "which responsibilities for purchasing and providing services were separated" (Donaldson & Gray, 1998: 38) in order to govern the use and allocation of resources (Beachey. 2008).

Central to the initiative was a system that established GP fund holders and "Health Authorities who could use their purchasing powers to choose between competing providers and so obtain the best services for patients. Service provider contracts could be signed with

hospitals and other health service organisations in either the public or private sector" (BBC News, 1999, September, 20). Initially, "Fifty-seven provider units became trusts and three hundred and six general practices" became GP Fund Holders (Kennedy, 2001: Chap 4: 23). These structural changes also led to the providers of health care becoming two separate entities - hospitals and community services.

These 1991 reforms intended to change the course of the history of the NHS (Harrison, 1991; Klein, 1995; Firelbeck, 1996), and they "were intended to diffuse blame to the market" (Klein & Maynard, 1998: 5). Greener (2004: 668) claimed that these reforms depended on restraining spending restrained and creating political accountability. But, "The internal market remained controversial throughout this whole period of operation particularly because professional staff and the public remained uncomfortable about notions of competition within a publicly funded service. The costs needed to sustain its transactions also aroused concern. So too did the general air of rivalry and confrontation which pervaded the service" (Donaldson & Gray, 1998:1).

Harrison & Wood (cited in Hann, 2000: 38) claim that *Working for Patients* "retained a number of central features of Conservative ideology, which include incentives for efficiency, a means of challenging the perceived unity of the medical profession and a broadly anti-statistic preference for markets, rather than planning, as the means of resource allocation."

Consumerism

The Griffiths Report (DoH, 1983: 10) advocated the concept of consumerism as an integral part of health services. This implied the need for managers to be more responsive to consumer needs, expectations and satisfaction. *The Patients' Charter* (1992) was designed to make the NHS more accountable to patients by clarifying health organisations' duties towards patients. League tables were introduced supposedly so that patients could evaluate the performance of hospitals, when making their choices about treatment.

However, the Charter had two key objectives:

> *"To give patients, wherever they live, better health care and greater choice amongst the services available; and greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences."*
>
> (DoH, 1989: 3-4)

The Patients Charter (1996: Introduction) was part of the overall Major government initiative around its *Citizens' Charter* requiring the NHS to "listen to and act upon people's

views and needs; set clear standards of service; provide services which meet those standards." One key emphasis was on waiting times. By these means the government aimed to give patients greater choice, by encouraging services which sought to satisfy the consumers through an incentive system.

Performance measurement

Improving NHS performance was to be done by improving the NHS's capacity to make it more efficient by raising the performance of all hospitals to a level of 'best practice' in all cases. Firstly, the initiatives driving this policy included, "delegation of responsibility for the delivery of healthcare to the local level: district health authorities, regional health authorities, and hospitals... [and] over all, the management of services remains cost-effective" (DoH, 1989: 14). Greener (2004) points out that although the government repeatedly emphasised the "need to take decisions at a local level rather than national level," it was "reluctant to release control, even putting in place ever more complex systems of performance measurements" (Greener, 2004: 667).

This implied the need for managers to be more responsive to consumer needs, expectations and satisfaction, to be more attentive to efficiency and effectiveness, and to pay much more attention to the importance of the role of performance measurement as means for achieving the goals. In respect of the control of doctors' performance, clinical audits were introduced in *Working for Patients* to ensure a "systematic quality control of treatments throughout the Health Service with, for the first time, all doctors looking critically at what they and their colleagues are doing so that they can improve their effectiveness and outcomes" (House of Commons, 1989: 38).

Managerialism and structural reform

Managerialism and structural reform was part of the shift of medical priorities towards more private-sector values and priorities, informed by 'New Public Management.' Some authors saw these as attempts to shift the traditional balance of power from medical staff to managers, supported by a more assertive leadership style, to local management and central government (Flynn, 1992; Hunter, 1994; Lewis, 1998; Farbey, *et al.*, 1999).

As a structural reform to reduce bureaucracy, improve service and to decentralise, the *Health Authorities Act* (1995) replaced Regional Health Authorities by regional offices of a new NHS Executive, heralded by *Patients First* (DoH, 1979) District Health Authorities were replaced by new Health Authorities. Powell (1994) suggested that the *Working for Patients* (DoH, 1989) reform showed "there was a lack of clarity about the role of Health Authorities," and an emphasis on the rhetoric of "localism, devolution and the local

community" (Powell, 1994: 114) and the policy possibility of "transferring power to local levels within the NHS" (Greener, 2004: 667). But Lock (1989: 1) claims that this was "a convenient cloak disguising the lack of local accountability" and it involved the transfer "for health care's failings from centre to the periphery, a device to shield the government from public anger."

Ferlie (1997) indicates that the Tory NHS policies tended to emphasise the need for decentralisation, but with upward accountability. However, citing Hoggett (1996), he shows that the intended transition to a post-bureaucratic structure, decentralisation and increased flexibility was far from straightforward and remains an ongoing issue for the NHS.

The most significant organisational change proposed in the *Griffiths Report* (1983) was "the development of general management in hospitals and the greater involvement of clinicians in budgeting through resource management initiatives" (Davies, *et al*, 2000: 112). This call for the introduction of new managerial control of the NHS was seen as one solution to existing health service problems identified by Griffiths. One main implication for NHS management was the appointment of general managers in the NHS with whom responsibility should lie. This new managerialism, represented by 'general management,' "represented a radical change to the organisation and management of the NHS" (Kennedy, 2001: Ch. 4, Para 11). "The number of general and senior managers rose from 1,240 to 20,010 between 1988 and 1993" (DH, Statistical Bulletin, 1994, cited in Iliffe & Munro, 2003: 318).

Additionally, doctors became more involved in cost and resource management. For example, "In 1986, the resource management initiative took over from management budgeting, as more concerted efforts were made to ensure that doctors throughout the NHS took responsibility for the management of resources and services" (Smith & Ham, 2000:3). Paton has suggested that one significant outcome of the Griffiths Report was the creation of the institution of NHS general management, and thus clinical-led management (Paton, cited in Hann, 2000: 10).

For example, "a number of management budgeting demonstration projects were launched to involve doctors in management" (Smith & Ham, 2000:5). They intended to provide "active, strategic direction and to devolve responsibility through a clear structure of line management and devolved budgets" (Kennedy, 2001: Chapter 4, Para, 11) to frontline staff, supported by "general managers of hospitals who would remain operationally and professionally accountable to their counterparts in the District Health Authority (DHA)"

(Kennedy, 2001: Chapter 4, Para, 13). Such a management system required that "doctors should be more closely involved in management," decision-making and practice (Smith & Ham, 2000:3).

The main contradictions of this major reform were that the empowerment of medical staff through delegation of responsibilities coincided with "a tightening of bureaucratic control mechanisms; arbitrary on-off systems of surveillance and control and a management style which confused elements of both high trust and low trust" (Cooke, 2006: 240). The reforms created "a subgroup of managerially minded professionals increasingly detached from their initial professional base" (Ferlie, 1998: 9), and so some doctors took on "new quasi-managerial roles" such as Clinical Directors.

The overall effects of these NHS reforms were re-centralising decision making, adopting strong managerial policies, accommodating a modicum of privatisation, and stressing the patients' role in some service choices. It was "not surprising that the NHS thus found itself operating in a turbulent and unpredictable environment where conflict rather than co-operation, and fragmentation rather than synergy were the order of the day, at least in the short term" (Burnes & Salauroo, 1995: 15).

2.3 Implications of Conservative initiatives on control of doctors' performance

This section analyses the implications of these Conservative reforms during the period 1979 to 1997 on the discourses around the struggle by the State for greater control of the medical professions. The introduction of the internal market structure in 1991 "was a logical extension of the 1983 Griffiths model of general management and corporatism," leading to an erosion of medical power (Ong, *et al.,* 1997: 89) as a result of the application of the marketisation and managerialisation of healthcare to improve service quality, efficiency and market responsiveness.

It was deregulation that was central to Conservative overall ideology rather than re-regulation. Thus increased regulation of the medical profession was not overtly imposed by the reforms. However, there was a need for government regulation necessary for safeguarding essential NHS values. Therefore Enthoven proposed the introduction of a new system of governance that combined 'regulation by directives' and 'regulation by incentives,' (Enthoven, 1988: 82-83) rather than specifically tightening the professional regulation of doctors.

An analysis of these reforms provides insights that may explain professional responses of NHS doctors to closer regulation and control of their profession, and the introduction of performance measures. Six inter-related issues are raised by these Conservative initiatives: the power of NHS managers; accountability and performance measurement, including appraisal; insertion of economic considerations between doctor and patient; direct challenges to medical autonomy; the shifting balance of power between management and doctors; and intra-professional power shifts within the medical profession.

The first issue concerns the increase of the power of NHS managers at the expense of doctors. Greener argues that the real purpose of introducing the internal market into health services was not "an attempt to impose a particular ideological solution upon the NHS" but "an attempt to strengthen the hand of managers" and was a way of confronting "the perceived unity of the medical profession" (Greener, 2004: 668, 665). Resistance to these changes was more evident than any evidence of change, suggesting that the desired transformation to a quasi-market system was taking place (Broadbent, *et al.*, 1992; Jones & Dewing, 1997). On the contrary, a government review at the time highlighted serious tensions that had emerged between budgetary pressures and consumer demands, and between centralised controls and medical autonomy (Day & Klein, 1989). These reforms were also perceived as a systematic attempt "to decrease the influence of doctors, increase management power and introduce an entrepreneurial and cost-conscious culture into the NHS. This power shift, understandably perhaps, gave rise to a significant degree of uncertainty, conflict and resistance" (Burnes & Salauroo, 1995: 15).

The second issue concerns accountability and performance measurement. The launch of internal markets and managed competition in the NHS which "emphasised performance management, the measurement and public disclosure of organisational performance, and the use of information as instruments of accountability" (Wood, 2002: 15). The earliest mention of appraisal as a form of performance measurement was found in the Griffiths Report: "to ensure with management that a policy for performance appraisal and career development operates, from the unit to the centre, to meet both the aspirations of staff and the management needs of the service" (op. cit. 9.3). The role of information within the appraisal process was later to take on greater significance. Appraisal imposed the idea that there was, and still is, a need for the medical profession to accept more collective responsibility for its work. However, in order to strengthen collective professional autonomy, in *Good Medical Practice* (GMC, 1995) the General Medical Council has placed more attention on the individual professionals. Also, the market structure extended the functions of general management and corporatism in the NHS, and the government

forced the medical profession to "take into account external, especially economic" responsibility for their medical decisions over the use of public resources. Here, "individual accountability of professionals has been transformed into corporate accountability" (Ong, *et al.*, 1996: 90).

The third issue was the insertion of economic consideration between patient and doctor, with a "move from trust to contract" (Klein, 1995: 314). For example, the new GP contract did not just change the "structure of the NHS but threatened the clinical autonomy of doctors" (Day & Klein, 1992: 469), by eroding their freedom to exercise their medical judgment over how to use public resources. As North, *et al.* (1999: 409) point out, "the discourse of markets, with its emphasis on costs and efficiency, has perhaps disrupted traditional professional discourses that centred on clinical knowledge and sought to exclude economic considerations from treatment decisions."

The reform changed the traditional hierarchical bureaucratic control, which was then replaced by a system of the "internal market with purchasers acting as proxy-consumers on behalf of their populations" in "a free, competitive market within the framework of a publicly funded service" (Klein, 1995: 301). By this means the government aimed to give patients greater choice, by encouraging services which sought to satisfy the consumers. However, the evidence Klein cited was that "consumers lack both the knowledge and the inclination for making market-like choices between different practices." Therefore, the beneficiaries of NHS reform were not the patients but the purchasers, health authorities and fund holding GPs who drove the market (Klein, 1995: 317-318; Greener, 2004).

The fourth issue was the direct challenge to medical autonomy. Compared to Griffiths, the 1991 internal market reforms presented more aggressive challenges to traditional professional autonomy and self-regulation in healthcare. 'New Public Management' ideology drove the attack on the autonomy and dominance of doctors working in the NHS (Dent, 2003a). And according to Klein, the reforms were "rightly perceived as a challenge to health care providers in general and the medical profession in particular" (Klein, 1995: 302). In short, Klein's argument is that the reforms demonstrated that the Conservative government at that time was clearly determined to gain power and control over doctors, which is a further contradiction in these reforms.

However, "whilst these reforms succeeded in changing some of the surface manifestations of medical culture, for example, the control of budgets and contracts, they were less successful in penetrating the deeply entrenched traditional professional values and beliefs

and power base that underpin the ideology of clinical autonomy. Thus, clinician autonomy had remained largely unchanged by these earlier initiatives (Jones & Dewing, 1997, cited in Davies, *et al*, 2000: 113). As North, *et al.* (1999: 410) show, it can be argued that these reforms led to GPs soon "reclaiming control of the NHS from managers and that GPs gained considerable power, if not the financial benefits, of fund holding" at management's expense.

In responding to the government's proposals, the medical profession seemed to show some willingness to restrict the autonomy of medical practice, but some suggested that they managed to adapt to the changing system (Ong, *et al.*, 1996). The profession became more cautious in protecting medical autonomy (Klein, 1995). However, individual autonomy was not substantially eroded because of *Working for Patients*. Indeed the market structure seemed, in part, to strengthen professional power despite the government's apparent intention to weaken it, because of the inclusion of doctors within the management system where they could also seek to protect the profession's interests in self-regulation. This is further discussed below.

The fifth issue was the shifting balance of power between management and doctors. The government had "demonstrated its willingness and ability to push these changes through without involving the medical profession in the policy-making process" (Day & Klein, 1992: 469). In this case, the reforms implied that the "medical profession had lost its ability to veto policy changes by defining the limits of acceptability" (Day & Klein, 1992: 474) and lost some input into the determination of the policy agenda. Therefore, "political and managerial power in the health service became more centralised after the reform" (Iliffe & Munro, 2003).

The reforms did not achieve their ideological objective of changing the architecture of power by replacing medical dominance with full managerial control. Moreover, the prestige of medical knowledge combined with the management role for clinicians gave an extra advantage to the medical professions to bargain over the degree of their autonomy. For example, the medical audit, which is essentially a professional matter, requires specialised knowledge of medical practice to access the medical records. Therefore, the accountability for professional performance is largely retained by peers: a degree of control has been protected from managerial intervention (Klein, 1995; Ong, *et al.*, 1996).

Nevertheless, the reforms changed the form of medical practice, and medical professional autonomy lost some traditional freedom of control. The reforms in theory imposed certain

bureaucratic constrains on the professionals' activities by organisational constraints, government regulations, and enhanced professional discipline (Haug, 1988), but in reality did not reach the level of intervention they were designed to achieve.

The market reforms created a confrontational tension between government and doctors. The medical profession was against the creation of Trusts, because of their freedom to set salaries and service contracts "so threatening the role of the national negotiating bodies like the BMA" (Day & Klein, 1992: 471-2). The profession also felt threatened by greater emphasis being put on the need for better systems for monitoring doctors' performance through modes of accountability such as the medical audit. Moreover, as in the case of the consultant contract, the distribution of power between medical professionals and managers implied that the managers would seemingly have great power over the medical profession, because the new consultant appointments have to involve managers in the revised performance management system (Day & Klein, 1992).

The sixth issue was the intra-professional power shift. North *et al.* (1999: 415) pointed out that "the creation of internal markets and more specifically, of fund holding reflected, and to some extent harnessed, the historic divisions within the profession, isolating consultants and GPs on either side of the purchaser-provider divide. The increase in the political power of GPs, derived from their commissioning role" under the internal market, destabilised former medical hierarchies (Klein 1995). There was a shift of power to primary care doctors from hospital-based consultants (Fitzgerald & Ferlie, 2000), so all-in-all there were both winners and losers resulting from these early government reform initiatives.

The new managerial roles of clinical and medical directors give professionals more power in respect of "resource allocation and decision in terms of safeguarding their clinical autonomy"(Ong, *et al.*, 1996: 90). On other hand, such a process was one of re-stratification within the profession in order to partially control medical practices, according to Coburn *et al.* (1997). These newly created clinical directors exercised technical control over their professional colleagues, "employing subtle processes of management by reciprocation, drawing on the concept of collegial relations" (Fitzgerald & Ferlie, 2000: 733). It has been argued by these two authors that these power shifts which created this 'hybrid' role for some senior doctors produced a form of professional control more efficient than other forms of external control.

To summarise, the "NHS has always relied upon a partnership between the government, doctors, and the medical professional bodies" who represent them. The reforms made "a

'double bed' relationship between government and doctors" and in doing so created a "more difficult situation for both parties" (Greener, 2004: 668). On the one hand, the government "despite offering real increases in funding did not expand health expenditure to the level recommended by the Royal Colleges" (Ham, 1999, cited in Greener, 2004: 665), and on the other hand it seemingly "attempted to interfere in medical affairs" (Greener, 2004: 668). The Conservative reforms blurred the distinctions between manager and clinician and fuelled the tensions between them; clinical decisions were no longer the exclusive domain of doctors.

2.4 Drivers and initiatives of Labour governments (1997 - 2008)

The New Labour government's health policy initiatives from 1997 to 2008 determined that the quality of healthcare should be the central reform issue in the NHS. The government indicated that "there would be a 'third way' of running the NHS, by combining the best from the market approach of the Conservatives, and the hierarchical approach of Old Labour" (Powell, 1999: 353). The strategy of improved quality was first set out in the White Paper *The New NHS, Modern, Dependable* (DoH, 1997). The healthcare policy agenda focused on improving service delivery, enhancing patient safety and controlling professional performance. However, medical malpractices around the turn of the century refocused the government thinking towards greater control of doctors.

Key drivers for change

The many drivers for change in the NHS may be grouped under four headings (Fig. 2.4). First were several health care quality issues, many arising from the internal market of the Conservatives. Second was medical malpractice, highlighted by seven public inquiries which all reported in the first five years of the new century. Third were issues of patient safety and increased awareness of the public and decreased trust in the medical profession. Fourth were increasing concerns about the effectiveness and efficiency of the complex self-regulation mechanisms throughout the medical profession. Many of these issues were and continue to be closely inter-related.

The Labour Manifesto of 1997 clearly set out a reform agenda, "Labour created the NHS 50 years ago. It is under threat from the Conservatives. We want to save and modernise the NHS" (Labour Party, 1997: unpaginated). *The New NHS: Modern, Dependable* (1997) was to form the basis for "a ten year programme to renew and improve the NHS through evolutionary change rather than organisational upheaval. These changes will build on what

has worked, but discard what has failed. The needs of patients will be central to the new system" (DoH, 1997: Introduction).

Healthcare quality issues

The marketisation of healthcare was anathema to Labour who, as with Kennedy (2001: Ch.4: Para 18), believed that the NHS was quite unlike any commercial business in that, "There were no major incentives available to persuade those working in the NHS to change their ways of working. Nor were the economic sanctions of the private sector available. If a business failed to perform adequately it was taken over or made bankrupt. The hospital had to continue to offer a service; it could not just be closed down." The new government's early initiatives were around the abolition of the internal market. They intended to maintain the purchaser/provider arrangement (DoH, 1997) through a system of "'integrated care,' based on partnership and driven by performance" (DoH, 1997: Para: 6.11). Klein (2003: 115) viewed this as "a mirror image" of the Conservative reforms, outlined in *Working for Patients.*

One concern was over the putting of institutional needs before those of patients' interests (Salter, 2003: 932) which had been emphasised in *A First Class Service* "the grey uniformity of central control [being] irreconcilable, both with clinical judgment and with individual patient needs" (DoH, 1998a: Para, 1.12). New Labour blamed the Conservatives for the long waiting lists, rationing of healthcare and inequalities, which the Labour Manifesto pledged to reduce. In the White Paper *A modern and dependable NHS* (DoH, 1997: 1) the government sought to abolish the internal market which "wasted resources administering competition between hospitals," with NHS staff effort diverted into "pushing paper."

The government seemed to shift away from managerialism and NPM principles which had "created tension within professional groups who feel themselves and their craft to be under attack" (Hunter, 1996: 799). Dent (2005: 624) points out that New Labour desired a move towards post-NPM in "a move from a managerial to a governance discourse – or more accurately from a discourse that emphasises managerial controls to one that emphasises self-regulation."

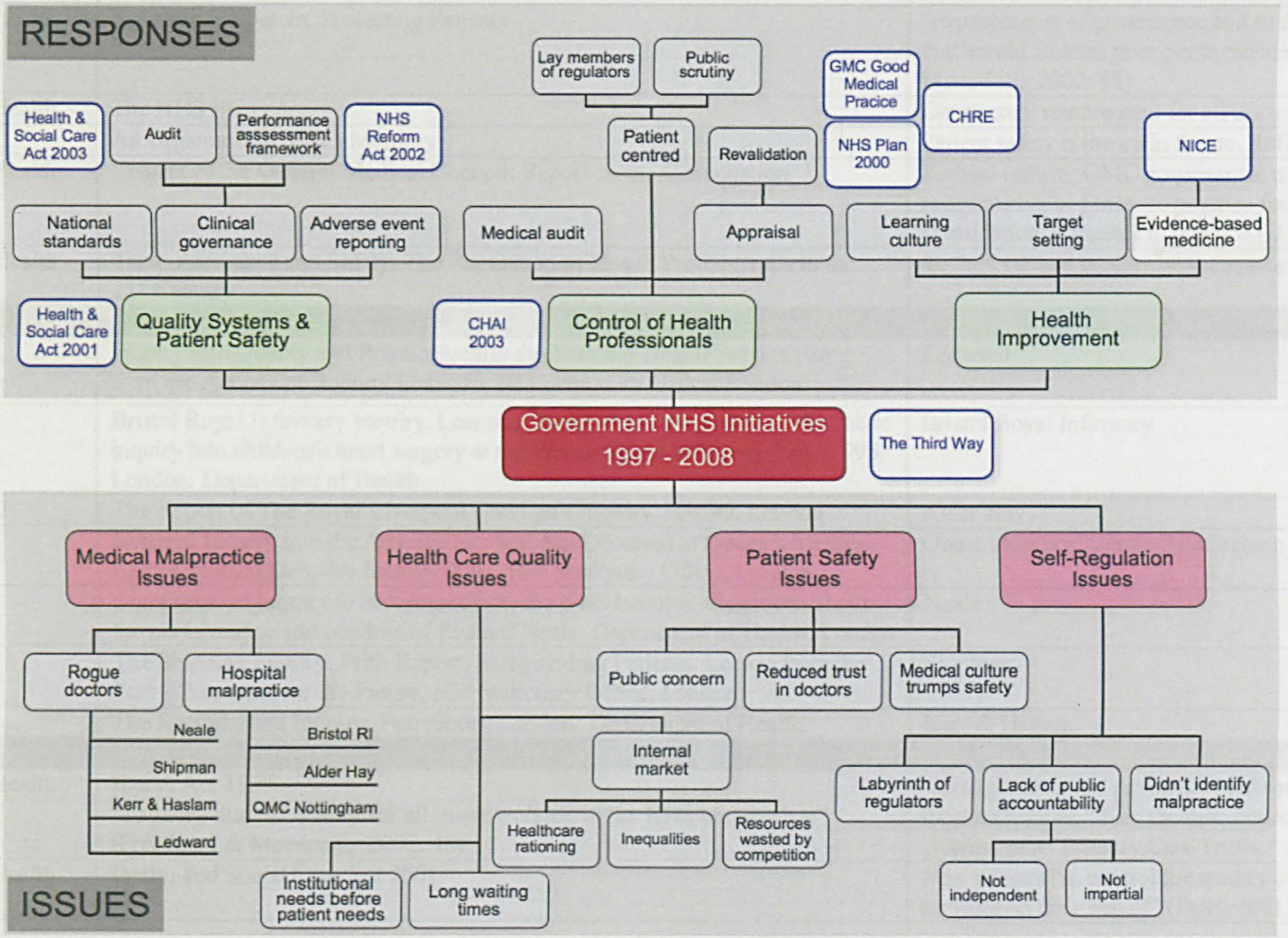

Fig. 2.4 Drivers and initiatives of Labour governments from 1997 to 2008 (Sources given in Fig. 2.5)

YEAR	AUTHOR(S)	PUBLICATION	COMMENT
WHITE PAPERS AND CONSULTATION DOCUMENTS			
1998a	*NHS Executive*	*A First Class Service: Quality in the New NHS "the concept of corporate accountability for clinical performance". (Freedman & Macaskill, 2002: 47)*	*Clinical audit replace medical audit, the introduced of clinical governance.*
1999a	Department of Health	Supporting Doctors, Protecting Patients	"requirements of governance and to the methods that would address poor performance of doctors" (Freedman & Macaskill, 2002: 48)
2000	Department of Health	The NHS Plan	Contractual requirement for all doctors to be appraised
2000	Donaldson *et al.*	An Organisation with a Memory	Patient safety is the main theme. References to adverse events.
2002	Department of Health	Reform of the General Medical Council: Report on the Consultation	Radical reform: GMC governance; more lay members; restructuring of fitness to practice framework; implementation of revalidation, + licence to practice,(DoH, 2002).
2007b	Department of Health	Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century	To "reform and modernise the system of professional regulation"
PUBLIC INQUIRIES			
2000	Ritchie, J.	Inquiry into Quality and Practice within the National Health Service rising from the Actions of Rodney Ledward, HM Stationery Office, London	Ledward
2000	Kennedy, Ian	Bristol Royal Infirmary Inquiry. Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. London: Department of Health.	Bristol Royal Infirmary
2001	Redfern, M. et al.	The Report of The Royal Liverpool Children's Inquiry. HMSO, London	Alder Hay
2001	Toft. B.	External Inquiry into the Adverse Incident that Occurred at Queen's Medical Centre, Nottingham, 4th January 2001. HM Stationery Office, London	Queens Medical Centre, Nottingham
2004	Matthews, S.	Committee of inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale, Department of Health. London	Neale
2005	Smith, J.	The Shipman Inquiry: Fifth Report; Safeguarding Patients: Lesson from the Past – Proposals for the Future, HM Stationery Office, London.	Shipman
2005	Pleming, N.	The Kerr/Haslam Inquiry: Full report, London: Department of Health.	Kerr & Haslam
LEGISLATION			
1999	Department of Health	Health Act 1999. "statutory duty of quality for all those working in the NHS became law" (Freedman & Macaskill, 2002: 48)	"arrangements and payments between health service bodies and local authorities " Key themes: Improving service quality: creating new 'Primary Care Trusts:' establishing CHI & NICE
2001	Department of Health	Health and Social Care Act 2001	New powers "to control the quality of those delivering those services on their behalf" (DoH, 2001).

2002	*Department of Health*	*NHS Reform and Health Care Professions Act 2002*	*"The creation of a Council for the Regulation of health Care professionals to oversea the activities of nine regulatory bodies of the health care professions" (DoH, 2002. Summary. Para.7)*
2003	Department of Health	*Health and Social Care (Community Health Standards) Act 2003*	*It "imposes a duty of quality on all NHS bodies that provide or commission health care…and by the CHAI in reviewing health care provision"(Explanatory notes, 2003: 1)*
2004	Department of Health	Human Tissue Act 2004	It make "provision with respect to activities involving human tissue" (DoH, HTA, 2004).
2004	Department of Health	Health Protection Agency Act 2004	"An Act to establish the Health Protection Agency and make provision as to its functions". (DoH, HAPA, 2004).
2006	Department of Health	NHS Redress Act 2006	"to reform the way lower value clinical negligence cases are handled….thereby improving the experience of patients"
2008	Department of Health	Health and Social Care Act 2008 Part of the Government's response to Shipman Inquiry.	Care Quality Commission - a new integrated. Reform of professional regulation to enhance confidence
2009	Department of Health	Health Act 2009	"measures to improve the quality of NHS care, the performance of NHS services, and to improve public health". (DoH, 2009).
GMC PUBLICATIONS			
1998	GMC	Good Medical Practice . Revised in 2001 and 2006 Comes into effect on 13 November 2006	"Serious or persistent failures to meet the standards in this booklet may put your registration at risk". (GMC, 2006).
1999	GMC	Revalidation – the profession moves forwards. GMC News 1999; Issue 5.	"[R]esponding to public concerns, stated that doctors in order to maintain their registration", (Freedman & Macaskill, 2002: 47)
1999	GMC	Management in Health Care – The Role of Doctors	"Registered medical practitioners continue to have a responsibility for the care of patients when they work as managers and remain professionally accountable to the GMC"
2000	GMC	Revalidating doctors: ensuring standards, securing the future.	With the principles of revalidation and proposals for its implementation.
2002	GMC	Consultation: Structure, constitution and governance of the General Medical Council.	Procedures for dealing with allegations against doctors
2003	GMC	A Licence to Practice and Revalidation. London: General Medical Council	"stated that most doctors will be revalidated on the basis of participation in appraisal"(Mohanna, 2005: 1)
2006	GMC	Management for Doctors - guidance for doctors	"All practising doctors are responsible for the use of resources; many will also lead teams or be involved in the supervision of colleagues; and most will work in managed systems"

Fig. 2.5 List of relevant reports, legislation and GMC responses.

Medical malpractice

Spanning the first and second Labour governments was a spate of public inquiries into medical malpractice - rogue doctors and hospital failings. These were The *Ledward Inquiry* (Ritchie, 2000), *Bristol Royal Infirmary* (Kennedy, 2000), The *Alder Hey Inquiry* (Redfern, 2001), *Queen's Medical Centre, Nottingham* (Toft, 2001), *The Neale Report* (Matthews, 2004), *The Shipman Inquiry* (Smith 2005), and *The Kerr/Haslam Inquiry* (Pleming, 2005). All of these raised public and government awareness of patient safety and the need to monitor the practices and performance of individual medical staff (Baker, 2001, 2002).

The inquiries refocused the reform agenda on to the need for tighter controls and the monitoring of individual performance (DoH, 1999; DoH, 2000; Donaldson, *et al.*, 2000). In order to "put problematic practitioners on the right track if local efforts fail, and speed up the process of excluding the irremediably poor performers" (Healthmatters, 1999:1). However, "in the great majority of cases, the causes of serious failure stretch far beyond the actions of the individuals immediately involved" (Donaldson *et al.*, 2000: viii-ix, Para, 8), influenced in many cases by NHS cultures.

The inquiry into Bristol Royal Infirmary paediatric failings also highlighted the need to examine the climate of NHS organisational culture, communication and control systems (Kennedy, 2001). Indeed, Donaldson *et al.* suggested that "a fundamental culture change is necessary to ensure that measures are introduced" to improve quality of health care and reduce adverse events (Nieva & Sorra, 2003:18), concluding that "culture is a crucial component in learning effectively from failures" (Donaldson *et al.*, 2000: 46).

One government response was the report *An organisation with a memory* (Donaldson *et al.*, 2000) which highlighted that adverse events (not all of them serious) occur in 10% of hospitals and cost £2 billion a year. This report concluded that the current NHS was clearly in need of a comprehensive and robust mechanism for managing the threats to patient safety, and required "new bureaucratic procedures that enable the managerial surveillance and regulation of health service quality and safety" (Waring, 2005: 687-688).

Patient safety issues

These cases of medical malpractice, amplified by media attention, raised public concerns about safety issues in the NHS. There was a reduced trust in doctors especially where it was revealed that medical cultures trumped patient safety in several of the cases. In 1998, the government seemed aware of the loss of public confidence in the NHS, since in *A First Class Service: Quality in the New NHS* (DoH, 1998) it signalled that "the challenge for the professions is to demonstrate that professional self-regulation can continue to enjoy public

confidence" (DoH, 1998; Para: 3.44). By 2000 the government was influenced by a radical change in thinking by placing patient choice before medical expertise (Greener, 2001). For example, *The NHS Plan* (DoH, 2000) advocates that the patient should be at the centre of care. This represented "a shift in the dominant ideology" (Salter, 2003: 927).

The NHS Plan indicated that "cultural dissonance between patients and doctors was now "a key political issue to drive NHS change in terms of improved health care, in order to restore "public trust in the medical profession" (Salter, 2007: 268). In the White Paper, *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century* (DoH, 2007b) the identification of rogue doctors was one aim but the public must perceive that regulation is working in the interests of patient safety and doctors must perceive the system to be "fair, just and supportive" (Buckley, 2007: 99). It was realised that regulation "must encourage and enable early intervention, initially at a local level, if a doctor's practice begins to deteriorate" (ibid.). This last point reflected the public inquiries, which raised the question of how long malpractice had continued unreported.

Several of the inquiries commented upon cultural deficiencies which contributed to the failings in the NHS. "The culture of secrecy, professional protectionism, defensiveness, and deference to authority is central to such major failures" (Walshe & Shortell, 2004: 103). The issue of culture was addressed fully in *An organisation with a memory* (Donaldson, *et al.*, 2000), which advocated that a learning culture instead of (an ineffective) blame culture is necessary for learning from the experiences. A blame culture can encourage people to cover up errors, "act against the identification of their true causes by focusing on individuals and ignoring the role of underlying systems" (Spencer, 2000: 412). Irvine (2006: 209) suggested that the problem of self-regulation within the NHS has as its underlying cause a "surly professional culture." Irvine suggests that this culture is too strong on individualism, poor on working in teams and is self-serving and thus not directed primarily towards patient safety.

Self-regulation issues

Professional self-regulation has been the traditional bedrock of medical autonomy (Klein, 1998a: 122). The official inquiries and the concern of the public were the drivers for the government to examine the issues of self-regulation which failed to identify malpractice in the seven cases. There was a "labyrinth of self-regulation" (Salter, 2003: 933) which generally lacked public accountability and transparency, being seen as neither independent not impartial, as identified the White Paper *Trust, Assurance and Safety, The Regulation of Health Professionals in the 21st Century* (DoH, 2007b). This was, in part, the government's

response to the recommendations of the Fifth Report of the Shipman Inquiry and other similar inquiries - Neale, Ayling, and Kerr and Haslam.

Irvine (2006: 209) argues that there is "an alarming lack of a sense of collective responsibility at the level of institutional leadership in the profession to make self-regulation work properly for patients." The UK has nine statutory regulatory bodies - for doctors, dentists, pharmacists, opticians, osteopaths and chiropractors, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the Council for Professions Supplementary to Medicine and the General Medical Council. Such overlap of regulatory structures might indicate that the government "struggles to reconcile the state's management ambitions with the labyrinth of self-regulation" (Salter, 2003: 933), with the potential for lack of consistency between them.

The General Medical Council's (GMC) role as the representative as well as the regulatory professional body is constrained by historic and informal understandings about regulation, which has been based traditionally on the principle of informal, collegial rituals and cultural practices (Rosenthal, 1995; Allsop & Mulcahy, 1998). The term self-regulation is understood as "being made up of a network of formal/informal and external/internal procedures at the macro, meso and micro levels of professional practice" that are ingrained in "the doctors' 'occupational' cultural norms, values and beliefs" (Warring, 2007: 165). The government argued that because of the weakness of professional-led regulation, particularly by the GMC, then, according to *Supporting Doctors, Protecting Patients* (DoH, 1999), it needed a fundamental change in its governance and culture.

Also criticised were the NHS procedures which failed to prevent, recognise and deal "effectively with the problem of poor clinical performance" (DoH, Health Service Circular HSC, Summary. 1999/065). Ministers were beginning to accept direct responsibility for clinical failing and it was becoming more difficult to "shelter behind the doctrine of clinical autonomy if things go wrong" (Klein & Maynard, 1998: 5). The government believed that there was a lack of national performance standards for the NHS and a need for the modernisation of professional self-regulation, which they categorised as medical governance failings in *A First Class Service* (DoH, 1998a).

The major government responses

During the eleven years from 1997 to 2008 there were a plethora of government initiatives which were its responses to the drivers of healthcare quality, medical malpractice, patient safety and self regulation issues. The aims of government reforms since 1997 were to introduce more accountability and transparency into the NHS, make it more cost effective,

with better control of performance, less bureaucratic and more integrated with other social service providers that were far more patient-centred (DoH, 1997a).

These initiatives may be arbitrarily grouped under the three headings of health improvement, quality systems and patient safety, and control of health professionals (Fig. 2.4). All of these variously and collectively contributed to the increasing concern with medical autonomy and many of these government initiatives have implicitly sought different means for achieving greater control over the medical profession. The medical malpractices demonstrated "failures in self-regulation and weak links between state and professional regulatory systems" (Kuhlmann & Allsop, 2008: 179). These prompted a policy shift to challenge professional self-regulation and impose a legal duty on doctors for patient safety.

Health improvement

A First Class Service: Quality in the New NHS (DoH, 1998a) set ambitious targets to improve health and reduce disease (Worcestershire Annual Health Report 7, 2006). This was to be achieved through developing a learning culture, setting targets and a move towards evidence-based medicine. The subsequent White Paper *The New NHS, Modern, Dependable* (DoH, 1997) led to the *Health Act* 1999 which set up the National Institute for Clinical Excellence (NICE) and the new statutory Commission for Health Improvement (CHI), "informed by annual national surveys of patient and user experience" (Hatch & Rollin, 2000:240), through the National Patient Safety Agency.

CHI's roles were to "oversee the quality of clinical services, disseminate good practice, and tackle shortcomings" (DoH, 1998a: Chapter, 4.6). Establishing NICE was a clear move to evidence-based medicine which affected clinical behaviours, especially "how clinical professionals judge credible evidence and take decisions" (Green & Plsek, 2002: 59). These new NHS regulators were partly constituted for target setting as well as monitoring professional performance.

There was a move towards patient-centric policies, but this approach created conflict with the guidance from NICE, because patients sometimes cannot have what they want (Cunningham, 2002), leading to adverse patient feedback. Within the orthodox patient-doctor relationship it is "impossible to conceive of a sustainable change in the power of patients without a corresponding shift in the power of doctors" (Salter, 2003: 928). In addition, the increased levels of performance measurement tools and standards of assessment placed further responsibility on doctors to raise activity levels, "which their

managers feel is required to meet the ever more stringent targets imposed by central government" (Cunningham, 2002: 138).

Health improvement was also to be underpinned by the fostering of a learning culture. This was a major theme in *An organisation with a memory* (Donaldson *et al.*, 2000), which "set the stage for an assessment of how the NHS should learn from adverse events [and] near misses" (Barach & Small, 2000: 1683). The report recommended that a learning culture should replace the 'blame culture' for professionals learning from health adverse and near miss experiences. A learning culture, it is believed, would help overcome the "conspiracies of silence that are identified as obstacles to organisational learning, covering error and hampering communication" (Hart & Hazelgrove, 2001: 257).

The subsequent initiatives emphasised the importance of 'safety culture,' which "can have positive and quantifiable impacts on the doctors' performance" (Flin, 2007: 656). "Organisational learning in the NHS was seen as a means of improving healthcare systems and making hospitals safer places for patients" (Hart & Hazelgrove, 2001: 257). Thus national reporting systems for adverse events were established and provided the data to inform policies to improve patient safety (Kennedy & Mortimer, 2007), based on an incident reporting system (Vincent, *et al.*, 2006).

Other initiatives for health improvement, heralded in the 1997 Labour Manifesto, were the establishment, for example, of a Food Standards Agency and the banning of tobacco advertising. Cancer was a main focus and "We will end waiting for cancer surgery" (Labour Manifesto, 1997: unpaginated). This necessitated the "requirement for inter-organisational collaboration" based on network modes of organisation "which places novel demands on professionals in the primary care sector" (Fitzgerald, 2003: 228). The 2000 *NHS Plan* recommended the promotion of "managed clinical networks for cancer [which] was a means of streamlining patient pathways and fostering the flow of knowledge and good practice between the many different professions and organisations involved in care" (Addicott & Ferlie, 2007: 393).

Quality and patient safety

The initiatives here were built around national standards, clinical governance and adverse event reporting. The White paper *The New NHS, Modern, Dependable* (DoH, 1997a: Para: 6.2) introduced formally the concept of clinical governance, "with the focus on improving the quality of care" and proposed "a new model that brought together responsibility for quality at the local level within a clear national performance standards framework," through National Service Frameworks and the National Institute of Clinical Excellence.

The subsequent consultation document, *A First Class Service: Quality in the New NHS* (DoH, 1998a) emphasised that high "standards will be delivered locally" and would be "monitored" (RCGP Summary paper, 1998:1). This initiative introduced for the first time "a statutory duty for quality improvement at the local level through clinical governance" (Donaldson & Gray, 1998: 37), thereby placing responsibility "at the top of local healthcare organisations" (Worcestershire Annual Health Report 7, 2006: 2). It proposed "the concept of corporate accountability for clinical performance" (Freedman & Macaskill, 2002: 47). The elements of the quality strategy are illustrated in Fig. 2.6.

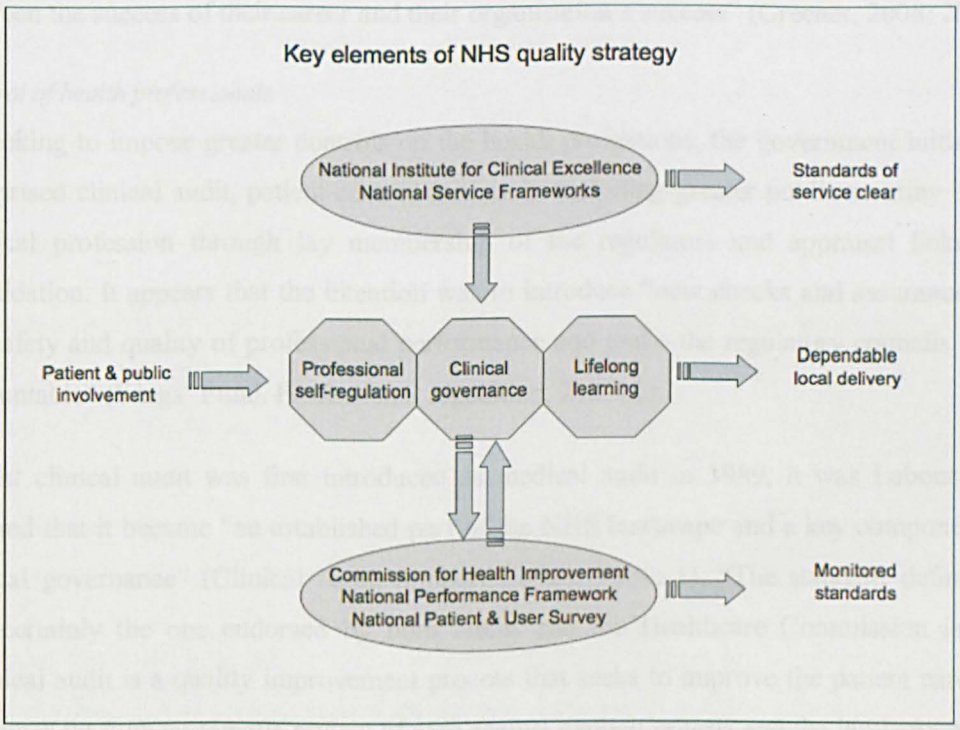

Fig. 2.6. Illustration of the key elements of the NHS quality strategy
(Adopted from A First Class Service, 1998)

Central to the early New Labour strategy was clinical governance "in that it provides a framework within which local organisations can work to improve and assure the quality of clinical services for patients" (Devon NHS, 2003). Clinical governance is both political as well as service-driven, "with a number of imperatives behind the public rhetoric, such as the failures of medical self-regulation, the political need to contain costs in a publicly funded healthcare system and the continuing wide variations in clinical practice" (Hall & Firth-Cozens, 2000: 3).

Now that clinical governance had been introduced into the NHS, the requirement was for "the creation of a culture as well as systems and methods of working which will ensure that

opportunities for quality improvement are identified" (Donaldson *et al.*, 2000: 2). However, clinical governance seems to be not only diverting substantial funds from direct patient care, but also, with its complexities, might have the unintended consequence of reducing service quality. Salter (2001: 876-7) wants to "curb the undoubted bureaucratic potential [and waste]" of this policy and sees "a large degree of functional overlap, duplication and confusion" in the regulatory arena (Salter, 2002: 64). Additionally, the increasing emphasis on performance monitoring has partly resulted in managers, cynical from continuous changes in the policy agenda, engaging in high risk "game playing" by encouraging them to "present their organisations in the best possible light in recognition of the potential link between the success of their career and their organisation's success" (Greener, 2008: 204).

Control of health professionals

In seeking to impose greater controls on the health professions, the government initiatives comprised clinical audit, patient-centred initiatives including greater public scrutiny of the medical profession through lay membership of the regulators and appraisal linked to revalidation. It appears that the intention was to introduce "new checks and assurances for the safety and quality of professional performance and make the regulatory councils more accountable" (Kings' Fund. Professional regulation, 2007: 1).

Whilst clinical audit was first introduced as medical audit in 1989, it was Labour who ensured that it became "an established part of the NHS landscape and a key component of clinical governance" (Clinical Audit Support Centre, 2009: 1). "The standard definition, and certainly the one endorsed by both NICE and the Healthcare Commission is that 'Clinical audit is a quality improvement process that seeks to improve the patient care and outcomes through systematic review of care against explicit criteria and the implementation of change" (Copeland, 2005: 3). However, in *Trust, Assurance and Safety* (DoH, 2007b), it was observed that clinical audit was falling short of its potential.

The patient-centric approach was further emphasised in *The NHS Plan* (2000) which "enlarged the bureaucracy of sponsored consumerism" (Salter, 2003: 932), by emphasising the empowerment of patients and privileging patient/citizen representation on the regulatory bodies above and beyond doctors' autonomy. The government thus "set out its minimum requirements for health care self-regulatory bodies" (Gray, 2002: 117). The outcomes required were:

> *"Smaller, with much greater patient and public representation in their membership; have faster, more transparent procedures, and develop meaningful accountability to the public and health service."*
>
> (DoH, 2000: 90; Para: 10.13)

More, it emphasised the need for stronger regulation of professional standards (DoH, 2000: 88). "One of the priorities of *The NHS Plan* and government proposals to modernise professional self-regulation was to formally increase lay involvement in all the regulatory bodies" (Gray, 2002: 117), even including the General Medical Council. It states that its plan is to reform the system and to introduce arrangements that ensure that "one third of the members of the NHS Modernisation Board will be citizen and patient representatives. The Commission for Health Improvement will [also] include citizen and lay inspectors on all its review teams" (DoH, 2000: 95; Para: 10.29, 30, 32).

Assuring the quality of medical practice (DoH, 2001) stated that it "continues to believe that self-regulation makes an essential contribution to maintaining and raising standards. But regulation has to be responsive to patients and public, transparent and accountable. We also want to see a co-ordinated approach to the modernisation of regulation across the health care professions" (DoH, NHS Executive; 2001a: 28).

The chief mechanism was to the setting up of the Council for the Regulation of Healthcare Professionals (CRHP), which "should, with statutory backing, build a new approach to professional self-regulation" (Gray, 2002: 118). CRHP's priorities were to facilitate "robust public scrutiny," greater consistency, and a requirement for "greater integration and co-ordination between the regulatory bodies and the sharing of good practice and information," and "the setting of new performance targets and monitoring" (ibid.).

However, there will be managerial challenges over the increase in lay involvement in all the regulatory bodies and greater patient and citizen representation generally within the NHS. The need to "be open and transparent and allow for robust public scrutiny" (Gray, 2002: 118) will add yet more pressures on a management system that has suffered a continual stream of policy shifts and reorganisations, at a time when management costs are being cut.

Trust, Assurance and Safety: The Regulation of Health Professional in the 21st Century (DoH, 2007b) further emphasised impartiality and independence by ensuring that regulators were not dominated by the government or any dominant interests. This White Paper indicated that regulatory framework must integrate the functions of standards and ethics, education, registration and fitness to practice. Closely linked to the changes in professional regulation was the third mechanism in the control of medical professional, namely the use of appraisal linked to revalidation.

It is striking that the earliest idea of appraisal was set out in the *Griffiths Report* (DoH, 1983: recommendation 9.3) "to ensure with management that a policy for performance appraisal and career development operates, from the unit to the centre, to meet both the aspirations of staff and the management needs of the service." The White paper *The New NHS, Modern, Dependable* (DoH, 1997: Para: 6.2) also emphasised the extension of "lifelong learning among staff and the modernisation of professional self-regulation" (RCGP Summary paper, 1998:1). *A First Class Service* (DoH, 1998a) recommended local CPD programmes and personal development plans. The driving force "for formal appraisal came from the introduction across the NHS of clinical governance outlined in the 1998 consultation document *A First Class Service – Quality in the New NHS*" (DoH, 1998a; Para: 2.11).

The criticisms arising from the cases of medical malpractice gave a greater sense of urgency to the publication of the new proposals in *Supporting Doctors, Protecting Patients* (DoH, 1999a), which "set out a structure for compulsory appraisal and assessment of doctors' performance" (Worcestershire Annual Health Report 7, 2006). It was aimed specifically at the need for greater and closer governance of medical performance and introduced the requirement that doctors' were to be charged with taking "responsibility for colleagues' performance" (ibid.). Most parts of this document reflected *Good Medical Practice*, first published by the General Medical Council (GMC, 1995). This was effectively a revised code of practice, issued to all doctors.

One purpose of *Supporting Doctors, Protecting Patients* was to "strengthen procedures for professional self-regulation through appraisal leading to revalidation" (DoH, Health Service Circular HSC, Summary 1999/065). Revalidation by the GMC was "supported by the medical Royal Colleges and the British Medical Association" and "the comprehensive new appraisal system for doctors in the NHS will provide the core information required by the GMC for revalidation" in *Supporting Doctors, Protecting Patients* (DoH, 1999a; Para: 5.18). In *A Licence to Practice and Revalidation* the GMC indicated that appraisal will be "a powerful indicator of a doctor's current fitness to practise" (GMC, 2003: 11).

Also, *Supporting Doctors, Protecting Patients* (DoH, 1999a) "significantly enhanced this scrutiny of poorly performing doctors by focussing on aspects of clinical competence, personal conduct, and ill health" (Worcestershire Annual Health Report 7, 2006). Its aim was to set out proposals to "prevent, recognise and deal with any poor clinical performance" of doctors in the NHS. It provided a clear interface with professional self-regulation (DoH, 1999a: Summary). "Now, the profession is expected to undertake regular,

approved training and continuous professional development programmes. Also mandatory is participation in clinical audit - the assessment of practice against set standards" (Worcestershire Annual Health Report 7, 2006).

It also set out what the government considered to be the prime aim of self-regulation. "The primary purpose of professional self-regulation is to protect the public. It should be a process through which designated professional bodies provide an assurance that individual practitioners are fit to practise in their chosen field" (DoH, 1999a; Para: 3.10). This was clearly laid down:

> *"Determining which individuals should enter and remain members of a health profession at different levels and in different fields of practice through supporting health organisations in achieving high standards of quality through clinical governance at local level and through other structures and processes at national level"*
>
> *(DoH, 1999a; Para: 3.9)*

The NHS Plan (2000) placed greater emphasis on leadership, accountability and appraisal. For example, additionally, a new contract for consultants was proposed, which "will make annual appraisal and effective job plans mandatory for all consultants" (DoH, 2000: 97; Para: 8.21). It proposed that "all doctors employed in or under contract to the NHS will, as a condition of contract, be required to participate in annual appraisal, and clinical audit, from 2001" (DoH, 2000: 90; Para: 10.10).

It was in *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century* (DoH, 2007b) that "the proposals for periodic revalidation of professional registration in which appraisal will be a key component" (RCN, National Standards and Strategies, 2007:2) was indicated. "For relicensure, all doctors will have a licence to practise that enables them to remain on the medical register. This licence to practise will have to be renewed every five years. In order to bring objective assurance of continuing fitness to practise, the appraisal process will include 'summative' elements which confirm that a doctor has objectively met the standards expected" (DoH, 2007b: 6)

The *National Health Service Reform and Health Professions Act* 2002 founded the Council for Healthcare Regulatory Excellence (CHRE) which had statutory powers to investigate and produce annual reports on the performance of the various medical regulators. The Council's powers were extended by the *Health and Social Care Act* 2008 which granted additional powers for reviewing cases where health affected doctors' fitness to practice. This now suggests that the Labour government wished to regulate the regulators and impose centralized standards.

2.5 Implications of Labour initiatives on control of doctors' performance

This section analyses the implications of these Labour reforms during the period 1997 to 2008 on the discourses around the State's struggle for enhanced control of the medical professions. Not all of the initiatives were driven by this perceived need for greater control of doctors. However, many of them either directly or indirectly had impacts on how doctors performed their clinical tasks. For example, under health improvement initiatives the establishment of NICE meant that doctors were not always allowed to prescribe the drugs that they wanted to. Also for example, under quality systems and patient safety, clinical governance has the effect of challenging doctors' working methods. This is especially relevant now that doctors have legal obligations to patients under the *Health Act* (DoH, 1999).

The government's emphasis on promoting "patient interest has been matched by its production of a range of policies designed to restrict the traditional autonomy of doctors" (Salter, 2003: 932). One of the drivers of change in the regulation of healthcare was "the quality of decision-making within the regulatory bodies [which] was a matter of strong public concern. This concern had intensified in recent years" (Gray, 2002: 117) with calls for improved public education and the willingness to challenge and question the decisions of professionals.

Appraisal and revalidation

Using a legislative approach, the government authorises persons to engage in the medical professions by virtue of meeting (usually minimal) educational and performance criteria (Covell, 1980). The key implication of *Supporting Doctors, Protecting Patients* (DoH, 1999a) both for NHS management and for doctors was the increasing emphasis on appraisal, now compulsory for doctors working in the NHS. The primary intention of appraisal is assist doctors to build their good performance (Elwyn *et al.*, 1999) and to recognise as early as possible causes of poor performance. This consultation document defines appraisal as "a positive process to give someone feedback on their performance, chart their continuing progress and identify development needs. It is a forward looking process deemed essential for the developmental and educational planning needs of an individual" (DoH, 1999; Para: 5.13).

The intention was for appraisal to be based on the GMC's document *Good Medical Practice* (GMC, 1995: 7), which describes "standards of competence, care and the conduct

expected of doctors in all aspects of their professional work." The guidelines cover such criteria as: "good clinical care; maintaining good medical practice; teaching and training; relationships with patients; working with colleagues; probity; and health" (ibid.). Appraisees are expected to produce a portfolio which is a dossier of evidence based on the guidelines listed above, collected over time.

Moreover, the Green Paper *Supporting Doctors, Protecting Patients* states that, "appraisal will form an important component of the systems required by the GMC for revalidation" (DoH, 1999a; Para: 5.14, 5.15). Under Labour the shift has been to the formal appraisal of doctors linked to revalidation, in which the government's power to grant licenses also extends to the development and surveillance of standards for medical practice. This is now seen as the key initiative changing the NHS (DoH, 2007b). "A priority for most health professionals is to strengthen regulation and revalidation through a more effective system for dealing with unsatisfactory practice and through CPD programmes" (Gray, 2002: 118).

Critiques of appraisal linked to revalidation

In fact, the current government's determination to monitor and control doctors' performance through appraisal, and improve health services has put the profession under great pressure. According to Redman (2000: 48) "the use of performance appraisal in the NHS has undermined the traditional systems of public accountability in the NHS," whilst Townley (1993: 236) suggests that appraisal as it functions over time is "sedimenting a more hierarchical, centralised and disciplinary model of the organisation." However, Salter (2003: 933) claims that the "reforms being introduced by the profession's self-regulatory bodies generally aim to improve their internal efficiency rather than open themselves to the external scrutiny of health consumers." Roberts *et al.* (2002) pointed out that currently appraisal "makes no claim that the process will be sensitive (identify poor performance), specific (identify educational needs), valid (reflect actual clinical practice), or reliable (behave consistently across cohorts of doctors)" (Roberts, *et al.*, 2002 cited in Zwanenberg, 2004: 686).

The imposed, intensive regulatory instruments of appraisal, revalidation or medical audit that doctors have to face may have de-motivated them. Smith (1998: 1540) suggested that "the dangers are that professionals' internal motivation (the most important aspect) is crushed, that their time is diverted into activities that are more bureaucratic than beneficial to patients, and that they resort to game playing to buck the system (something at which doctors are highly skilled)." For example, "doctors relying for their revalidation on five

appraisals might be tempted to set easily achievable objectives in their personal development plans, rather than risk failing to meet a challenge" (Zwanenberg , 2004: 686).

On the face of it, revalidation is perceived as being merely "a mechanism that allows health professionals to demonstrate that they remain up-to-date" in terms of their medical knowledge and training, and are thus fit to practice (DoH, 2007b: 32). However, although the appraisal process is seen in this way by the government, as the basis of the revalidation process, this still remains a concern for many within the medical profession. It has been seen by some doctors as a control mechanism, such that, "Revalidation is part of an increased bureaucratic control being applied to professional self regulation" (Zwanenberg, 2004: 686).

The main criticism of appraisal linked to revalidation came from one of the conclusions of the Shipman inquiry (Smith, 2005). This report suggests that the standards and criteria being used to assess a doctor's 'fitness to practice' were too low and that revalidation was being based on an appraisal process designed for an entirely different purpose. "Information gathered under the 'knowledge and skills' framework for appraisal should be used as far as possible as the basis of revalidation" and this implies that the appraisal evaluation will be both summative and formative (DoH, 2007b: 34). The formative basis of appraisal is generally educational in nature but the summative basis deals in performance standards. The first is bottom-up whilst the second is top-down. Thus, "there is a natural, potentially creative tension between the two purposes of appraisal" (Taylor, *et al.*, 2002: 668).

2.6 Conclusion

The first aim of this chapter was to address one underpinning research question around the factors which seem to have influenced successive governments' apparent desire to increase its regulation of doctors. The various drivers for NHS reform were political, ideological, financial, structural, and organisational often emphasised by public (and media) concerns over the state of the health service. Efficiency and cost effectiveness were emphasised by the Conservatives, informed by New Public Management. Concerns over healthcare quality and patient safety were the initial drivers of Labours reforms which following a spate of medical malpractice cases shifted more towards issues around self-regulation.

The second aim was to answer a research question which asked what initiatives various governments followed to increase control of the medical profession. "From its inception the NHS has been in an almost continuous state of reorganisation with ever-changing targets."

(Beachey, 2008: 2). The evolution of NHS reforms of both Conservative and Labour governments during the last 26 years has demonstrated several ideological shifts, both between and within different political parties. They have displayed contradictions between "centralisation versus decentralisation; empowerment versus tighter control; hierarchy versus competition" (Cooke, 2006: 224).

Whilst many of the initiatives did not directly impact the control of doctors, most of them had indirect effects. The Tory reforms of marketisation, consumerism and managerialism affected (often adversely) the relationships between patients and doctors but their initiatives around performance measurement began to erode medical autonomy and set the scene for subsequent Labour reforms focusing on quality systems and health improvement but especially those measures designed specifically to control health professionals.

The third aim was to exemplify these control issues using the case of appraisal linked to revalidation and to answer a further research question around the functionality of appraisal. Appraisal, first mooted by Griffiths (DoH, 1983), was a later focus of the Labour government, which linked it to the licence to practice through the revalidation process. However, this initiative was closely linked to clinical governance so that "if appraisal is to be effective, robust and consistent, it is important that the clinical governance framework within which it operates is appropriately designed for its increased role within the regulatory system" (Shaw & Armitage, 2007: 217). The functionality of appraisal as both a formative and a summative process has led to tensions.

These government initiatives and their drivers have shown how, over the last quarter of a century, public services and their management have been "subjected to a whole assemblage of regulatory practices" (Nettleton *et al.*, 2008: 333): audit has percolated all areas of public service. This audit function is intended to make the NHS more accountable and efficient. The various initiatives shifted from the enforcement of managerial functions within NHS management (DoH, 1983) to a focus on the need for more efficient use of public funds through market mechanisms (DoH, 1989), through to dedicated health quality improvement initiatives by means of clinical governance (DoH, 1998a). The continuous policy shifts have led to healthcare becoming a 'hybrid' organisational form in which "hierarchy is strengthened and yet markets and competition are valorised" (Cooke, 2006: 224). Because of these, a new model of medicine is beginning to emerge and this has been called "scientific bureaucratic medicine" (Harrison, 2002: cited in Nettleton *et al.*, 2008: 334).

However, the main focus of this chapter has been the question of the control and accountability of doctors that has always been an issue for the State. The chapter has examined a range of policies since 1979, which have influenced the changing dynamics of the professional autonomy of doctors. These seem to be designed to help provide the State with the means to gain greater power over doctors than it has had since the NHS's foundation.

The clinical governance concept, introduced by the Labour Government early in its term (DoH, 1998a), dominated the structure for reforming professional regulation. The philosophy of this was the government adaptation of the corporate governance concept (Scally & Donaldson, 1998) into clinical governance in an attempt to "challenge the power of the professional monopolies" (Woods, 2002: 6). It was influenced by the Conservative and Labour initiatives. However, according to Meldrum (2007: 2) many of the policy proposals are very unrealistic when put together.

Nevertheless, clinical governance provided the framework through which "NHS organisations are accountable for continuously improving the quality of their services and for safeguarding high standards of care" (op. cit.: 33). The frameworks and mechanisms of clinical governance have "shifted the balance [of power] in favour of political and administrative accountability" (Woods, 2002: 7).

This clinical governance architecture implies that the government attempted to force doctors actively to accept collective responsibility rather than relying on the more prevalent individual responsibility of the medical profession. The government view that self-regulation was a barrier to progress in clinical governance has been challenged by Kuhlmann & Allsop (2008: 179), who argue that "barriers to governing medical performance are embedded in policy frameworks and are not simply an outcome of the self-regulatory powers of doctors."

The 'modernised' regulatory regime brings three specific challenges for the NHS management system. First is the need to ensure the maintenance of newly introduced quality systems. Second is the necessity of ensuring that the audit culture is not merely illusory, because the audit process encourages those being audited to develop coping strategies where it is more important for doctors "to be seen to comply with performance measurement systems, while retaining as much autonomy as possible" (Nettleton *et al.*, 2008: 334-5). So the apparent transparency of such regulatory mechanisms may actually delude managers and create a situation where they are merely being convinced rather than

genuinely assured doctor's practices are in fact 'excellent'. Third, there is the danger that additional managerial responsibilities for the appraisal systems, which underpin revalidation, if insufficiently resourced and poorly supported, may overload the local organisations (DoH, 2007b: 40).

The mechanisms of appraisal and revalidation may be seen as the means of maintaining collective autonomy with improved individual responsibility (DoH, 2006; DoH, 2007b). However, "the assessment of doctors can be perceived as threatening or intrusive, rather than as providing opportunities to define individual strengths and identify areas of learning" (Murphy, *et al.*, 2008: 96). But Meldrum (2007: 2) points out that the professionals "do not believe that stripping out the fundamental aspect of professional-led regulation is the correct way to ensure patient safety." Kuhlmann & Allsop (2008: 185) echo this view when they argue that "hierarchical State-led governance over health policy has strengthened in the NHS in ways that have fractured customary forms of state-profession bargaining."

Indeed, Buckley (2007), who is head of strategy and planning of the GMC, indicates that the 2007b White Paper does incorporate most of the GMC's key proposals for regulating the medical profession. He refers to the GMC's "unique accountability, which the White Paper underlines and reinforces, for the fitness for purpose of the medical register and the fitness to practice of those on it" (op. cit.: 99). Thus it is the role and nature of the revalidation process outlined in the White Paper recommendation that is of the greatest concern to medical professionals, and the fact that NHS appraisals will be used to provide information that will serve as the basis for revalidation.

This chapter has reviewed the literature on the struggle for control of the medical profession from a government perspective. Therefore the next chapter will concentrate more on the perspectives of the medical profession. It will provide the theories and concepts around issues of control with which to interpret the drivers and initiatives addressed in this chapter and also provide one basis for analysis of the data.

Chapter 3

SRUGGLES OVER CONTROL IN THE NHS: A FORCE FIELD ANALYSIS

Organisational control:

"[A] process of guiding a set of variables to attain a preconceived goal or objective." (Moores & Mula, 2000: 94)

"[P]ower and influence based on the concept of authority." (Das, 1989: 461-462)

3.1 Introduction

The paradox between State control and professional self-regulation and the battle for control is a long-term phenomenon within the NHS. Some public sector analysts and public policy theorists have argued that control has always been an issue for the State. For example, Dent (2006: 461) has observed that the ongoing influence of the managerialist agenda has eroded the assumptions underpinning regulation within the "medical profession, which has been the target of increasing external state control" (2006: 461). The previous chapter addressed the drivers for change, the consequent reform initiatives and the implications of these on the control of doctors, generally from the perspective of the government. The changing dynamics of the professional autonomy of doctors in the light of the call for greater NHS control of clinical performance. This control of clinical performance is the landscape in which NHS doctors seek to understand the recently introduced appraisal linked to validation.

The aims of this chapter, concentrating more on the doctors' rather than the government's perspectives, are to address two subsidiary research questions concerned with why doctors want to retain professional autonomy, and the means by which they seek to protect this autonomy when challenged by the State. However, the chapter is based on a framework of the various academic theories and concepts of control and their manifestation in the NHS, which is a key preliminary research question. Using Lewin's field theory to map the complex totality of the field (Burnes, 2004), the driving and restraining forces over the control of doctors, as illustrated by appraisal linked to revalidation, will provide a structure for this chapter (Fig. 3.1). The focus of reform from the government's point of view was to establish the power of "managerial control over doctors" (Salter, 2007: 263), whilst for

doctors the focus was on ensuring the quality of medical performance and the preservation of their traditional autonomy (Allsop & Mulcahy, 1998; DoH, 2001).

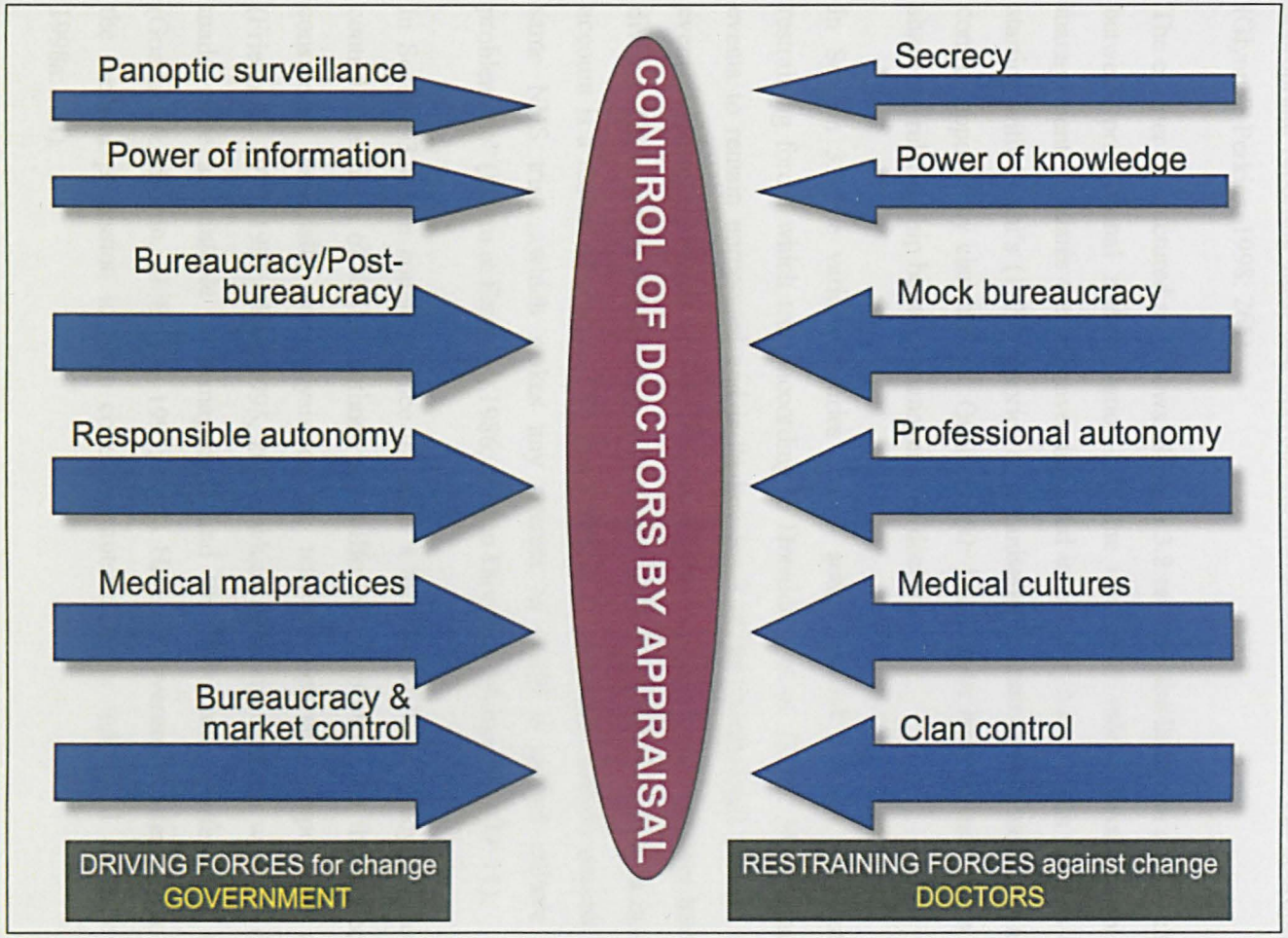

Fig. 3.1 Force field illustrating the driving and restraining forces over control of doctors, illustrated by appraisal linked to revalidation (Based on Lewin, 1951)

Managerial control has been defined as a "cybernetic process of testing, measuring, and providing feedback" with respect to a clear goal structure (Santana & Robey, 1995: 23). Organisational control is part of a management system and the managerial processes (Friedman, 1977; Worthington, 2004). All control systems, in other words, "require objectives, measures or standards, a measurement process, interpretation of data, appropriate reporting lines and appropriate management action at the appropriate level" (Glynn & Perkins, 1998: 265).

The chapter is structured as follows. Section 3.2 reviews the literature around the tensions between professional self-regulation and the quest for more direct control by NHS management. It relates the initiatives analysed in Chapter 2 to various theories of control, starting with Ouchi's (1977) theories of organisational control with hierarchy and market control opposed by clan control. Ouchi (1980: 140) shows how various forms of control shape the relationship between managers and doctors.

In Section 3.3 the various theories around some medical cultures are related to the restraining forces which tend, according to Donaldson *et al.* (2000: 35) to cause adverse events to remain unreported and is "a key issue in the institutional context of adverse events." However, Parker (2000: 187) warns that "organisational cultures have multiple divides. The extent to which certain affiliation or schisms will be called upon in a particular account is a matter of context." So that multiple cultures "can and do coexist within the same NHS trust....which makes any attempt to instill a unified culture somewhat problematic" (Bourn & Ezzamel, 1986, cited in Davies & Mannion, 1999: 11).

In Section 3.4 as a counterbalance to Ouchi's theories of bureaucracy, market and clan control, the views of further authors with different perspectives on the subject are now considered, especially an analysis of the tensions between 'responsible autonomy' (Friedman, 1977, 1987; Dent, 1995, 2005), which is an arrangement whereby doctors are made more accountable to management and the State, and 'professional autonomy' (Goddard & Mannio, 2006; Dent 1995; 1998). Here the government attempted to "persuade the medical profession to trade collective autonomy for individual autonomy" (Klein, 1998a: 124).

Section 3.5 explores the tension is between bureaucracy/post-bureaucracy and mock bureaucracy. The analysis will assess the extent to which the State shifted healthcare from bureaucratic to post-bureaucratic control, to overcome bureaucratic rigidities and professional inflexibility and overcome the mock bureaucracy that doctors had created

(Gouldner, 1954; Jermier *et al.*, 1994; Hynes & Prasad, 1997). The internal market may have created a 'mock bureaucracy' since "many of the bureaucratic cues were present – rules, posters calling for their enforcement, and inspections – but in the ordinary day-to-day conduct of work, this bureaucratic paraphernalia was ignored and inoperative" (Gouldner, 1954: 75).

Section 3.6 reviews the tensions between Townley's (1993, 1997) adaptation of Foucault's panoptic surveillance based on the power of information, and the doctors' resistance based on the power of knowledge, reinforced by the clinician as manager. Kitchener (2000: 148) has shown that many clinicians who take on clinical director roles do not necessarily shift their allegiances "from their peers and professional associations to general management," and in fact may remain quite protective of established medical-related values rooted in traditional professional autonomy. The government sought to achieve a shift in responsibility from the organisation to the individual (Maravelias, 2003) through surveillance, which "turns employees into self-disciplinary subjects of managerial control" (Worthington, *et al.*, 2006: 2).

Section 3.7 addresses the control of doctors through the mechanism of appraisal leading the revalidation in the context of the driving and restraining forces. The conclusion in Section 3.8 addresses the three underpinning research questions.

3.2 Tensions between bureaucratic & market and clan control

In reviewing the control theories that may be seen to be at work in the NHS, particular attention is focused on an analysis of organisational control developed by Ouchi (1979) - bureaucracy, market and clan. These controls are often exercised differently in different organisational settings and different organisational forms, and often in combination. For example, Scherer (1988: 475) argues that, "bureaucracy needs to be complemented by alternative models, which are general, neutrally descriptive and operational." However, what make the NHS distinctive are theses various control forms that can be identified. The driving forces for reform - bureaucracy, market and the 'third way' - may be opposed by the restraining force of clan control.

Bureaucracy

Bureaucratic control is based on the principle of monitoring professional behaviour through hierarchies, formal rules and the regulation of practices, based on "a norm of reciprocity and for the idea of legitimate authority" (Ouchi, 1979: 838-839), based around "a system of

hierarchical surveillance, evaluation, and direction" (Ouchi, 1980: 134). Ouchi considered that bureaucratic organisations "are the most efficient means for an equitable mediation of transactions between parties" (Ouchi, 1980: 140). Mayrhofer (1998: 242) considered that bureaucracies are superior to markets because, "the employees belong to a common organisation, [so] there is the basis for achieving an atmosphere of trust," which "reduces the degree of opportunistic tendencies and the amount of control required."

Control in the NHS through bureaucracy is related to such criteria as rationality, the need for centralisation, to support economies of scales and concern for the quality of care and for efficiency (McKinlay &Arches, 1985). The government made the NHS accountable through regional tiers of control and to the NHS Management Executive, to ministers and ultimately to parliament - a bureaucratic form of governance. Boyne (1998) considers that bureaucratic control implies that senior policy-makers have direct control over staff and other resources. Ham (1999a: 126) viewed the NHS as "a classic example of the centralised, bureaucratic organisation in which politicians at the apex sought to control the behaviour of staff at the periphery through a combination of central planning and national directives."

The strengths of bureaucratic control of the NHS lie in its ability to generate "organisational loyalty, devotion and primary allegiance" through "reinforcing and rewarding behaviour characterised by rules orientation, habits of predictability and dependability and internalisation of the enterprise's goals and values" (McKinlay &Arches, 1985: 79). Further, the "strength of a hierarchical organisation is its reliability" and the way in which "it is suited to repeatedly produce high volumes of goods or services in high-speed operations" (Jones, 1999: 167). Bureaucratic control is the most efficient mechanism to control a huge organisation and the only way to deliver human services to large masses of people (McKinlay & Arches, 1985). Bureaucracy also has the benefit of "monitoring employee performance so as to minimise opportunism" (Burke & Goddard, 1990: 394).

Nevertheless, bureaucratic control in the NHS has its disadvantages. For instance, the size of the NHS might generate problems because, "workers may not share the organisation's goals and have to be closely supervised. As the size of the organisation increases there needs to be more levels of authority, thus creating the potential problems of evasion and incompetence" (Tullock, 1987; cited in Robinson *et al.,* 2000: 40). A further criticism is that bureaucratic control leads to "increased alienation and frustration" (Friedman, 1987: 290), which Ouchi (1983: 85) describes as "alienation, anomie, and a lowered sense of autonomy."

Much cited is the criticism that the crude top-down control "appeared to act more as a disincentive than a driver for improvement" (Greener, 2008: 208) for many in the NHS, who tend to prefer a bottom-up approach which was sensitive to local situations. Despite its manifesto promise not to "return to the top-down management of the 1970s" (Labour Manifesto 1997: unpaginated), the NHS's hierarchical governance has been strengthened through the Labour government's initiatives, by engaging "a broader range of players in steering policy goals" (Kuhlmann & Allsop, 2008: 185). The top-down implementation of government policies, implying bureaucratic control (Klein & Maynard, 1998), may increase alienation between doctors and managers, since "the way in which regulations are introduced and enforced will have a significant impact upon the behavioural responses of managers and workers" (Gouldner, 1954: 296).

Market

Market control rests on the ability to control performance through the allocation of resources. Ouchi (1979: 838-839) claimed that "the norm of reciprocity is critical" in a market control form. Ouchi further argued that "market relations are efficient when there is little ambiguity over performance, so that the parties can tolerate relatively high levels of goal incongruence" (Ouchi, 1980, cited in Moores & Mula, 2000: 94). In "a market relationship, transactions are mediated by price" (Billing, 1998: 147), which suggests a form of competition. Within the public sector, this may take the form of inter-organisational competition for resources as "a powerful and appropriate means to improve public sector performance" (Moore, 2000: 112).

In the NHS, marketisation, for example the internal market and contracting out, was introduced by the Conservatives. Informed by Griffiths (1983) there was a rise of more entrepreneurial models of public management, through the use of market-like mechanisms – internal markets on healthcare based on the economic nature of hospitals (Burke & Goddard, 1990) with pressures "to secure efficiency gains and value for money" (Ferlie, 1998: 3). The imposition of the internal market appeared to replace goal congruence with competitive behaviours.

The perceived benefits of market control were to reduce inefficiencies and indifferent performance, which were produced by the monopoly position of the NHS bureaucracy. In contrast, market provision promises better performance as rival suppliers strive to win and retain public contracts, but managerial discretion is ceded to the contractor. Ascher (1987) argues that market-like contracting has been employed for the purpose of reducing costs, often through lower pay rates. It also was seen as one solution to the limited resources

available to the NHS. Managers were considered to be "entrepreneurs engaged in attempting to configure patterns of care delivery from the limited and constrained resources they have available" (Greener, 2008: 207)

Disadvantages of market control included "difficulties of defining and measuring healthcare outputs" according to market criteria "coupled with the under-developed" arrangements for costing in the NHS, made this reform expensive and problematic (Jones, 1999: 164). And according to Hughes and McGuire (1992: 109) the internal market was "partially disguised, top-down control." In other words, it became in effect a quasi-market, but "hierarchical forms were confronted by sharp fluctuations in demand and unanticipated change... in supply" (Jones, 1999: 167).

Clan

Clan control rests on the idea of networks as forms of regulation between professionals within the organisation as a means of exercising social control (Ouchi, 1979). Clans could be considered as an "informal social system [that] serves as the basis of control" (Ouchi, 1979: 838-839). With clan control "self-direction replaces hierarchical direction to a great extent which enhances commitment, loyalty, and motivation" (Ouchi, 1981: 83). Clan control has been viewed positively by Ouchi in his study *Theory Z* (1981), which posited the Z organisation, employing clan control, and easily adapted to organisational change, leading to organisational efficiency. The clan form of control gives people "a higher sense of personal autonomy and freedom" (Ouchi, 1983: 85).

In the NHS, self-regulation may be considered as a form of clan control, which is not driven by market forces or hierarchy, but professional values and self-interest. This type of control has been a persistent feature of control in the NHS, with Lapsley contending that the NHS exhibits "some of the governance characteristics of Ouchian clan control" (Lapsley, 1993; cited in McMaster, 1999: 1148). Dent (2005: 632) has observed that, "despite the rhetoric of a patient-led NHS based on networks of hospitals and clinics, the reality remains a Rousseaunian 'soft' bureaucracy of enforced self-regulation."

Advantages of clan control are that under certain conditions it may offer low transaction costs (Ouchi, 1980: 140). Kirkpatrick (1999) argues that the network (clan control) is a superior institutional arrangement to either markets or bureaucracy. This is partly because, "clans have their strengths in minimising goal incongruence" (Ouchi, 1981: 83). Moores & Mula (2000: 95) concluded that, "the clan provides great regularity of relations and may, in fact, be more directive than the other mechanisms. A variety of social mechanisms reduces differences between individual and organisational goals and produces a strong sense of

community" (Mayrhofer, 1998: 243). It has further been argued that in the contest between clan and bureaucratic control "professionals will generate a higher quality service if left to develop their own particular quality sub-cultures" (Hart, 1997: 266).

Disadvantages of clan control are firstly around legitimacy. Ouchi suggested that "clans may employ a system of legitimate authority, but it is often based on traditions rather than rational/legal forms" (Ouchi, 1979, cited in Moores & Mula, 2000: 95). Whilst a strong clan culture tends to maintain clinical autonomy, it is resistant to change (Ascher, 1987) and at the same time it seems to tolerate high levels of ambiguity in performance evaluation (Ouchi, 1981: 83). The destructive tendencies of opportunism which bureaucracy may reduce through "close auditing and hard contracting" are not easily achieved in a clan culture (Ouchi, 1980: 137). However, doctors "display a high degree of discipline achieved through the belief that individual interests are best served by achieving group interests" (Moores & Mula, 2000: 95). Market mechanisms were seen is opposition to clan, but how far one could dominate the other is not as clear as Burke & Goddard (1990: 394) seem to suggest: "The establishment of competitive medical teams will mean the destruction of the clan culture of the NHS."

Tensions between bureaucracy, market and clan in the NHS

All three forms of control suggested by Ouchi are to be found in the NHS. Since the NHS was founded it has been controlled politically by "competitive examination and organised on hierarchical lines" even though "informal power remained with key professional groups (such as doctors) who retained control over most clinical developments" (Ferlie, 1998: 3). How bureaucracy, market and clan interact is more difficult to unpack, but the changing interactions produced by different government initiatives often create tensions between managers and doctors. Labour governments recognised tensions and adopted a 'third way,' trying to "bridge the gap" (Ham, 1999a: 173) between markets and bureaucracy. Klein (1995: 251) argued that "neither a managerial hierarchy nor an advance to a laissez-faire market therefore is a plausible option."

The Labour government recognised that "health care markets are natural, spontaneous creations but have to be managed and planned in order to ensure that purchasers actually have choice" (ibid.). Independent trusts and foundation hospitals were promoted, placing the NHS into a hierarchies-market continuum. The internal market was to be abolished, cooperation would replace competition, by the use of "new forms of inspection, regulation, and the publication of information on comparative performance" (Ham, 1999: 173). Subsequent initiatives featured the main themes of "patient choice, provider competition,

and payment by results" (*The NHS Plan*, 2000, cited in Klein, 2007:12). However, these policies have created "a regulated market" by central government, which defines "the framework within which providers and commissioners operated and independent regulators would monitor quality and standards" (ibid.).

This Labour focus on quality may be seen as "a useful emblematic statement with which higher management attempts to wrest a degree of bureaucratic control away from the perceived power of the clinical staff and other producer groups" (Hart, 1997: 266). The quality agenda was pursued through "explicit written down standards, which are monitored" and became "the norm for individuals and institutions" (Zwanenberg, 2004: 687). But, "the highly disciplined nature of clans is due to the congruence of individual interests with that of the whole. It cannot be achieved by tightly monitoring contracts as performance ambiguity would make this prohibitively costly" (Burke & Goddard: 1990: 394).

The impacts of the interplay between these three control mechanisms on self-regulation and control of performance are complex and produce paradoxes. First, is the perceived necessity for close supervision. Ouchi (1979: 842) described hospitals as "professional bureaucracies" because of their highly selected individuals with both the skills and the values, which the organisation needs. Furthermore, Ouchi believed such organisations also contain "high levels of commitment" of its members, because the individuals' goals are congruous with their organisations' goals. This, he argued, dispensed with the need for close supervision. But integrating self-regulation within the institution of the NHS as a "network-based regulatory framework [which] creates a paradoxical situation" (Kuhlmann & Allsop, 2008: 185). Therefore, this is unlikely to exercise a close measurement of performance output, because performance evaluation takes place "through the kind of subtle reading of signals that is possible among intimate co-workers but which cannot be translated into explicit, verifiable measures" (Ouchi, 1980: 137; cited in Kohli, & Kettinger, 2004: 364).

The efficiency of the three different forms of organisational control - bureaucracy, market, clan - over performance measurement are associated, according to Ouchi (1979: 842), with issues of commitment, identification and compliance. A further issue that of reciprocity and socialisation should also be added to these three. All four issues have different impacts on the control of performance.

The first issue is commitment. With market control, the organisation's goals need to be congruent with the individual's personal goals; the organisation relies on the commitment of each member. With market-type mechanisms, internalised commitment is necessary because of the desired focus on individual profit. So, there is no "hierarchical monitoring or policing capabilities" (Ouchi, 1979: 842) needed for close control in a market. With bureaucratic control, on the other hand, commitment is far less critical. In clan control, internalisation is needed and the forms of control and monitoring are less strong, because the organisation relies on individual high commitment. In the NHS clan control has proved effective, from the doctors' perspective, because it is a network-based regulatory framework based on professional commitment.

The second issue is identification, which has a pre-eminent role in clan control. "A clan can also be supported with identification" and the identification may be transformed "into internalisation of the values of the clan" over time (Ouchi, 1979: 842). Identification is also relevant to bureaucratic and to market control. However with bureaucratic control identification is at a lower level of intensity, requiring mere compliance. "Compliance is the minimum level of commitment necessary for bureaucracy control, but it is beneath the threshold of commitment necessary for the clan and market forms" (ibid.). In medicine, the internalised values of a 'medical or clinical' clan is forged during professional training and socialisation into the profession, and reinforced throughout doctors' careers, through the principle of professional self-regulation.

The third issue is compliance. Berger argued that "every group exacts some degree of conformity or compliance as its price of membership and this is not always felt as a constraint" (cited in Blau & Goodman, 1995: xi). Compliance in clan control comes from peer pressure, whereas compliance in market control comes from competition. For bureaucratic control, compliance is of greater importance than commitment or identification. As Ouchi theorised, "the fundamental mechanism of bureaucratic control involves close personal surveillance" (Ouchi, 1979: 835), reflecting Foucauld's theory of the disciplinary power of surveillance. "[T]he Foucauldian internalisation of discipline is a highly effective strategy for ensuring that dissent is stifled" (Parker, 2000: 230). This author argues that belief by staff that they are valued motivates hard work, "disposing of the need for visible, and potentially costly, technologies of control" (ibid.). (See Section 3.5).

The fourth issue is around norms of reciprocity and socialisation, which are relevant to bureaucratic, market and clan control. Here, the control types are very much dependent on the extent of the organisational activities in terms of the degree of norm reciprocity. For

example, the clan control type presented by Zola & Miller (cited in Freidson, 1974: 160) shows that the reciprocity implicit between general practitioners and specialists was "an informal collaboration" in which "the specialists provided expertise which supplemented the general practitioner's limited knowledge and skill." Similarly the GPs "had reciprocal arrangements for 'covering' each other during illness, days off and vacations" (ibid.) Mayrhofer (1998: 254) argued "that the clan mode, with its culturally based coordination and control, represents a very strong and effective way of behavioural influence."

Within a market system, control "requires the norm of reciprocity and a (more or less) clear understanding of the valuation of supply and demand, i.e. of pricing" (Mayrhofer, 1998: 251). Granovetter (1985) criticisms the concept of hierarchy control, arguing "that socialisation of individuals can occur so that personal and organisational goals move into closer congruence, thus reducing the need for hierarchical control over individuals' behaviour" (cited in Jones, 1999: 165-166). Jones (1999) argued that clans can exist within a bureaucratic control system, and may provide "less overt control over a sub-set of individuals, while the remainder of the hierarchy is controlled in a formal manner" (Jones, 1999: 166).

In summary, Powell (1991) has examined the shifting balance between markets, hierarchies and networks (clans) in the NHS, and points out that all three forms have always been present in the NHS, which has been a blend of impure forms of quasi-markets, quasi-hierarchies and quasi-networks. The implication is that such institutional complexity poses problems for an evolution of 'what works' of those management forms in practice. The top-down control of bureaucracy is mediated by "the fragmentation of its formal regulatory functions, its reliance on informal professional networks, its multiple loci of power" (Salter. 2004: 120). This fragmentation acts as a constraint on "any state ambition to take it over" (ibid.). However, the strength of the medical profession is weakened by the lack of any over-arching coordinating body "capable of producing a unified response to pressures for reform and managing the politics of change" (ibid).

3.3 Tensions between medical malpractice and medical cultures

The driving force of medical malpractices, identified in Chapter 2, may be opposed by the restraining force of medical culture, derived mostly from the clan. The clan form of control is closely related to medical cultures, often built through collaborative working practices. These relationships may result, for example, in a club culture, membership of which might also grant privileges. Such medical cultures might reduce the incidence of reporting medical

malpractice. Indeed, Kennedy (DoH, 2001) identified club culture as a contributory factor in the adverse events in the paediatric cardiology department of Bristol Royal Infirmary. His inquiry concluded that power gradients led to the exclusion of subordinates, with the result that members of 'the club' consistently failed to respond to a mass of evidence from junior staff about poor clinical performance.

Wilkins & Ouchi (1983) have taken the paradigmatic view of the relationship between the efficiency of the organisation's culture and organisational performance. They claim that "the local organisational culture is the dominant form of control" and "organisational control cannot be adequately or accurately understood without a comprehension of the culture of the organisation" (1983: 469). Donaldson *et al.* (2000: 35, iv) seem to agree that "a key issue in the institutional context of adverse events is that of culture." *An organisation with a memory* suggests that "a fundamental culture change is necessary" in respect of reporting, learning and safety cultures (Robertson, 1998; Corcoran, 1998; Billings, 1998; Kohn et al., 2000) in what is an inherently risky organisation (Leape, 1994).

Medical cultures may be implicitly opposed to the development of reporting and learning cultures. One aspect of medical cultures may be fear of litigation which may militate against reporting systems, because "there is the tension between the complete and accurate identification and documentation of errors needed for quality improvement, and the institutional and professional fear of legal discovery in medical malpractice litigation" (Layde, *et al.*, 2002: 1994). Fostering of a learning culture may be opposed by organisational cultures, which will hinder the learning processes. "[In] the self-deceiving organisation, those in authority treat error as synonymous with failure and seek to place blame on some guilty party. In response, the organisation's members become skilled in hiding such errors." (Korten, 1984: 176). Organisations with a blame culture or with a lack of a learning culture are resistant to learning from failure and thus seldom possess a safety culture.

However, there are many caveats around culture in the NHS. First, Wilkins & Ouchi (1983: 478) claim that "culture is hard to change." They further argue that, "the organisation's culture may be less relevant to organisational performance than is generally believed" (op. cit.: 469). There seems to be resistance to culture change in the NHS since "in the face of major re-structuring continuity is more apparent than change, since the dominant culture attempts to neutralise the impact of any reform" (Davies & Mannion, 1999: 11). These authors cite the example from the 1980s of the imposition of resource management initiatives on to the medical sub-culture. However, it "met with strong resistance and

largely failed to have substantial impact on clinician autonomy" (Jones & Dewing 1997, cited in Davies & Mannion, 1999: 11).

Second, clan culture is an extremely potent force which has been present in the NHS since its inception. "It is hard to break down the barriers generated by professional training, years of working in institutions and where people are suspicious of the reasons for change, especially if it comes from the 'top' with adequate rationale" (Maddock & Morgan, 1998: 235). For example, club culture may have the effect of inhibiting the flow of information between different levels and units in the organisation and may hinder problems being adequately identified and addressed (Kennedy, 2001). Irvin (2006: 209) identified that the 'medical clan' causes weaknesses in self-regulation because "it is still strong on individualism and weak on team-working and collective responsibility."

Third, cultural change by itself should not be seen as a panacea for poor performance since it is only one of many relevant variables (Williams *et al.*, 1996). Indeed, seeking to change organisational culture is "unlikely to be a 'quick-fix' solution" to the problems (Davies & Mannion, 1999: 11). Because "multiple cultures can and do coexist within the same NHS trust, albeit with the dominant sub-group being the 'medical clan' which makes any attempt to instil a unified culture somewhat problematic" (Bourn & Ezzamel, 1986, cited in Davies & Mannion, 1999: 11).

Fourth, Parker (2000: 230) argued that if culture is manageable "it is a form of discipline that should be treated with extreme caution." However, Wilkins & Ouchi (1983:478) claimed that "organisational performance cannot be adequately...understood without a comprehension of the culture of the organisation" and have suggested that "some forms of culture will promote and some will inhibit efficiency" of organisations. But Parker further suggested the condition of culture is managed, "in the sense of a managerial attempt at intervention, but outcomes of this intervention can never be totally controlled" (ibid.). Therefore, Parker (2000: 188) concluded "organisational culture might be best formulated as something like the 'contested local organisation of generalities.'" Thus, the culture of a certain group of doctors or individuals cannot represent the culture of the entire NHS.

In summary, the literature seems to show that government agendas have sought to influence NHS cultural change as part of its aim to achieve greater control over doctors, driven by the spate of medical malpractice cases around the turn of the century. Clan control was seen by several authors as one contributory factor in failing to report adverse events and in learning from them. However, the cultural approach has limitations. These are that culture is hard to

change because of the dominance of clan control which weakens self-regulation within the NHS and that managerial attempts to change are unlikely to succeed because of the diversity of cultures within the NHS. Cultural change by itself is not a panacea, since there may be multiple cultures even within one hospital.

3.4 Responsible autonomy and professional autonomy

The opposing forces of responsible autonomy and professional autonomy came into focus with the Labour government, which sought to replace the professional autonomy (or self-regulation) of doctors with responsible autonomy, including commercial and managerial responsibility of medical staff. Responsible autonomy may be contrasted with direct managerial control, which seemed to underpin the Conservative initiatives. Responsible autonomy, with its emphasis on governance, appears to be a direct challenge to professional autonomy. Kuhlmann & Allsop (2008:185) suggest that "policy drivers and strategies play out in the differing architecture of governance and customary practices in state-profession relations" and they place self-regulation "in the wider architecture of changing governance practices."

Friedman (1987: 290), from the perspective of labour process theory in general industry, addresses the issue of management control strategies, in which "the influence of market conditions is mediated by the interplay between worker resistance and managerial counter pressure." Friedman (1977) distinguishes two types of strategy for the exercise of control used by senior managers - responsible autonomy and direct control. Friedman argued that 'responsible autonomy' was granted most frequently to privileged workers. By giving the worker this autonomy, status and responsibility, "it is hoped this will win their loyalty to the organisations' ideals of competitive struggle, hence increasing productivity and enlisting the worker support in the continuing process of adoption to changing conditions" (Friedman, 1981: 47).

Using this concept of responsible autonomy, Dent (2005) studied clinical governance, and the changing boundaries in the medical professions, with particular reference to nursing, and related these to government regulation of the health profession. He addressed the NHS reforms around the introduction of the Council for the Regulation of Health Professions (CHRE) as well as NICE, the Commission for Healthcare Audit and Inspection (CHAI) and the National Service Frameworks (NSF). He sets his study in the context of the 30-year (generally unsuccessful) attempts of government to force the medical profession to accept

greater accountability and work more flexibly. He references Friedson's work (1970) on professional dominance of specific professions.

Dent recognises the change from self-managed clinical governance towards evidence-based medicine based on what he calls 'responsibalisation' (responsible autonomy) which is state-managed. However, the doctors have maintained much control of the division of labour in healthcare. In identifying an emerging compact between the State and nursing, with a role in the implementation of clinical governance, and the creation of "clinical nurse specialists" (op.cit: 8), he sees an extension of nurses' roles into the domain of doctors, especially in routine and less complex cases. With responsible autonomy, Dent sees the intention of government policy as "the bulk of the profession will increasingly be 'interpreters' translating evidence-based medicine, NICE advice and NSFs into local guidelines" (op. cit.: 11).

An example of this responsible autonomy is the new medical-manager hybrid role of clinical director in which "the institutional forces influence change and inertia in professional roles," is achieved "through their acceptance of increased commercial and managerial responsibility" (Kitchener, 2000: 150). Nevertheless direct control persists in the NHS management systems, based on the principles of scientific management, with well-defined lines of authority "designed to determine all aspects of job design and work organisation through close managerial control" (Worthington, 2004: 64). For example, the command and control of central management is presented in the White Paper *The New NHS* (DoH, 1998), which indicated that the government intended to take direct responsibility for managing and directing NHS changes. One such change has seen a significant central monitoring and 'enforcement' role to maintain professional standards and quality of service, to achieve greater public accountability, transparency and to emphasise professionalisation.

It is debatable whether Dent would see the creation of as NICE and CHAI, which gave the central government new tools for monitoring, controlling and imposing sanctions at arm's length as direct control rather than responsible autonomy, (*A First Class Service,* DoH, 1998a). Such managerial mechanisms Bolton (2004: 318) observed have "heightened the desire to control the labour process of health professionals." Klein & Maynard (1998: 1) identified that there is tension between these two control tools. In "promoting good practice through education and persuasion, the role of NICE may be at odds with imposing it through sanctions, via the commission." They concluded such command and control mechanisms "concentrate blame and conflict" (ibid.).

Responsible autonomy appears to be a direct challenge to professional autonomy. The problem of self-regulation is considered to be "an alarming lack of sense of collective responsibility at the level of institutional leadership in the profession" Irvin (2006: 209). Dimmock (1977: 125) suggested that when professionals "attempt to exercise control through the threat of, or the application of, sanctions subsequent events may prove that they underestimated the power of management resistance." However, in reality clinical activity and clinical quality control "remained outside the reach of the centre" and "indeed an extraordinary degree of professional autonomy has always existed" (Goddard & Mannion, 2006: 68). These authors observe that the NHS has long been collegial "with local resource allocation and service planning decisions controlled by self-regulating profession groups" (ibid.).

Direct control by NHS management of clinicians' activities in the interest of patients is likely to encounter resistance from professionals. Under the ideology of self-regulation, management control by "non-clinicians was unacceptable" for the professionals (Salter, 2004: 70). Doctors have traditionally preserved self-regulation, because "the territories of medical regulation can only be adequately administered by the professionals themselves" (Salter, 2004: 141). Thus responsible autonomy, which relates directly to doctors, was seen as a better alternative to direct control. Other scholars have suggested that traditional professional autonomy has been eroded and the government gives the GMC's pressure that "the regulation of the profession is warranted" (Lock, 1989: 137). However, it appears "that the balance of power between doctors and managers" (Sheaff, *et al*; 2003: 87) is shifting towards managers, despite the rhetoric of devolved responsibility (Allsop, 1985, Coburn *et al.*, 1997, Waring, 2005). However, loss of power is partly compensated for by increased salaries "as NHS doctors are more highly paid than doctors in other European countries" (Kuhlmann & Allsop, 2008: 183).

Responsible autonomy, however, places managers in the paradoxical position where "they were accountable not only for their own performance" but they also "held accountability for the aggregate decisions of a group [of doctors]." Doctors "whose professional ideology, founded on an historic concordat with the State, insisted that its members should only be accountable to each other" (Salter, 2004: 72). Ham (1998b: 753) has suggested that devolution may result in "blame diffusion" with some individual doctors being reluctant or fearful of taking individual responsibility in clinical decision-making.

However, Parker (2000: 118) identified that the bureaucratic and autocratic manner in which NHS management approached problems would result in doctors "distancing

themselves from responsibility for management, now and in the future." Such a conflict might be created by the problematic of the balance of power between professional autonomy and responsible autonomy.

Goddard & Mannion (2006: 73) recognised the possible benefits of flexible accountability (or responsible autonomy) but "there is a risk that such mechanisms will weaken incentive structures for organisations to perform well on official measures, especially where a high degree of autonomy is enjoyed regardless of measured performance against central targets." This devolution of responsibility reflects Friedman's (1977) responsible autonomy, in which the organisation's control over the employee's own work is achieved by devolving the responsibility, in respect of accountability to them.

Worthington (2004: 64) draws attention to Friedman's claim that "management finds it extremely difficult to shift from RA [responsible autonomy] to DC [direct control], and vice versa." However, these two control strategies are useful for understanding "the current attempts to engage doctors in transformational attempts in the NHS." Dent (1995, 1998) also suggests that Friedman's responsible autonomy and professional autonomy shed some light on "the medical profession's values, beliefs and reasons for its resistance to change" (Worthington, 2004: 64).

In summary, Friedman's (1977) responsible autonomy and direct control framework does illuminate the decentralising tendency in the current NHS. Responsible autonomy may be seen as a move towards a post-bureaucratic organisation. As Budd (2007: 536) indicated, "The demand for flexibility within post-bureaucratic organisations suggests a greater absorption of the individual into the world of work, shifting between different roles and capacities. In this context, personalities, social relations, and individual interests may become subjugated to the instrumental concerns of the organisation"

In moving the NHS "from a bureaucratic to a post-bureaucratic" organisation, the challenge, therefore, is how to overcome the tensions between a monopoly of special medical knowledge power, traditional professional autonomy and the inflexibility of the NHS managerialism (Bäcklund, & Werr; 2008: 759). Post-bureaucracy seems to be one alternative for solving the problems of NHS control patterns. It is another quick fix? This issue is explored in the next section.

3.5 Bureaucracy/post-bureaucracy and mock bureaucracy

The driving force for change from bureaucracy to post-bureaucracy is opposed by the restraining force of mock bureaucracy. This section addresses the difficulty of making doctors accountable, and measuring and managing their performance because of the essential characteristics of bureaucracy and the traditions of medical self-regulation. It also shows how the shift to post-bureaucracy appeared to be a means of correcting this problem. The section traces the evolution from bureaucracy to post bureaucracy to overcome the issues of mock bureaucracy. This relates directly to the introduction of appraisal linked to revalidation, which is one indicator of a post-bureaucracy, and discusses the research question concerning the government's aim to bring about more effective State control and close regulation of doctors.

The strengthening of bureaucratic management in the NHS was initiated by Griffiths (DoH, 1983) with the creation of the unit general manager, whose span of control was wider than that of managers in most other organisations. This reduced the health professional's role in management and had a significant impact in shaping the conflict between doctors and managers (Ferlie & Pettigrew, 1996). It would seem that "an essential pre-condition for the implementation of the internal market was making the NHS more open to political influence through the creation of a management culture of command and obedience" (Butler, 1992: 53).

Bureaucracy

Dent (2005: 632) observes that the NHS system still "remains essentially driven from the centre" but exercises that central control "more by protocols and guidelines than edict" (op. cit.: 626). However, NHS control seems to operate on multiple, intertwined levels, creating "conflicting pressures or commands from different authorities" (Berger: cited in Blau & Goodman, 1995: xi). Cook's (2006: 239-240) study of the control of nursing concluded that, "with a tightening of bureaucratic control mechanisms, arbitrary, on/off systems of surveillance and control, and a management style which confused elements of both high trust and low trust in an unstable hybrid [organisational form], which combined authoritarian bureaucracy with an ostensible commitment to enterprise and empowerment." Kelly & Glover (1996) argue that little "has actually altered the original bureaucratic structure of the NHS" (cited in Bolton, 2004:320). Indeed, the NHS hybrids show characteristics of 'mock bureaucracies' (Gouldner, 1954).

Harrison & Smith (2003: 246) suggested that the pattern of management control within the NHS "was largely created interactively as an aggregate of individual clinical decisions,

leaving managers and planners weak in the face of any medical opposition, and managerial conflict with doctors was generally avoided. Managers were reluctant to question the value of existing patterns of service or to propose major changes in them." Some aspects of the bureaucratic structure are established to serve informational needs, in which Jones (1999: 167) suggest that "management divides up tasks and staff appointments and establishes a system of order" based on legitimate authority. Thus, formal decision-making is instituted; clearly defined boundaries between departments have been established.

Detailed reporting structures have been created and clear lines of authority are now strongly influenced by senior executives, such that "bureaucratic regulation will live on, but with the loci of power shifted towards the top...necessary counterbalance to a growth of self-protective behaviour and fair practices at provider level" (Hughes & McGuire, 1992: 109).

Mock bureaucracy

This 'self-protective behaviour' may take the form of mock bureaucracy, especially where a lack of legitimacy is perceived by doctors. This can become manifest in a disregard of rules or their lack of enforcement (Gouldner, 1954; Hynes & Prasad, 1997). In a study of a police bureaucracy, Jermier *et al.* (1991) suggested that "official/formal organisational missions and rules are frequently subverted by multiple organisational sub-cultures, which formulate and enact contrary sets of norms, goals and values" (cited in Hynes & Prasad, 1997: 607).

It is perhaps the complexity of bureaucracy, market and the 'third way' that could have led to the use of mock bureaucracy in the NHS (Gouldner, 1954). This can create difficulties for management control, since "rules are perceived to have little intrinsic value" and any rule violation is perceived to result in few negative consequences (Elliott & Smith, 2006: 295). As a result, key groups in the organisation may fail to accept or comply with the rules (Hynes & Prasad, 1997; Jermier, *et al.*, 1991). Mock bureaucracy appears to have been utilised by some doctors to resist initiatives to impose a firmer managerial grip. The medical profession continued to strive to maintain its dominance through formalisation of professional control and the reinforcement of stratification within the profession (Freidson, 1988, 1994; Harrison & Pollitt 1994), even under bureaucratic control.

The fact that a clan control system of self-regulation exists within the NHS bureaucracy, might indicate that the NHS is in reality a mock bureaucracy. This mock bureaucracy might be reinforced by management's acquiescence, since "management's decision not to actively enforce regulations can even promote a sense of harmony and co-operation between the two groups" - managers and doctors (Hynes & Prasad, 1997: 607). Similarly, the apparent failure of the NHS internal market could be interpreted as a failure of "internal compliance

to organisational rules" (Hynes & Prasad, 1997: 607). This covert organisational non-compliance is 'mock bureaucracy' "within this particular type of bureaucratic pattern, although various rules are in place, they are not enforced by either managers or workers because they do not hold as any legitimacy for either group" (Gouldner, 1954: 185).

Post-bureaucracy

Conscious of the failings of bureaucracy and of the presence of mock bureaucracies, there seemed to be an apparent shift, mainly under the Labour government's influence, from bureaucracy to post-bureaucracy. Maravelias (2003) suggests that one key feature of post-bureaucracy is that it repositions responsibility for the relationship between doctors and NHS managers from the organisation to the individual. Ferlie (1998: 6) implied that "these changes of organisational form also often heralded the removal of traditional rules and regulations so as to create a more flexible managerial environment." Post-bureaucracy, based on empowerment and shared responsibility (responsible autonomy), includes individuals in organisations, whereas bureaucracy is non-inclusive (Budd, 2007). It is constructed around decentralisation, consensus and porous boundaries.

The government position was that "the management of public services and associated ideology is the promise of the end of bureaucracy, to be replaced by organisational variants of post-bureaucracy" (Budd, 2007: 531-532). Maravelias's (2003) study provides insights "for understanding autonomy and control in post-bureaucratic" organisations. The author identifies two opposing discourses around "post-bureaucracy - managerial and critical management" (op. cit.: 547). The former sees post-bureaucracy as "an emancipating regime based on the personalities and social networks of individuals," whilst from a critical management perspective it is viewed as "a totalitarian regime, which subordinates individuals' thoughts, emotions and identities to its instrumental schemes" (ibid.).

In the 1990's reforms there are decentralising elements in the government's policy for control of the NHS (Ham, 1998; Bossert, 1998; Klein, 2003). Maravelias explains the essence of post-bureaucracy as decentralisation of power, which is immanent in networks of medical practice. He argues that post-bureaucracy "emerges as simultaneously more totalitarian and more democratic than bureaucracy: being more totalitarian because it lacks clear boundaries...and seeks to subordinate aspects of the personalities" and "more democratic, because these incessant expansionist powers follow an inclusive, not exclusive, logic" (Maravelias, 2003: 562). From a critical perspective, Grey & Garsten, (2001) suggests that post-bureaucracy is merely an extension of control in a different guise.

To summarise, doctors do not want directly to sabotage managers but there is still a temptation "to chip away at management power" in order to achieve "a power-sharing arrangement" (Derbet *et al.,* 1990: 437). But mock boundaries between professional autonomy and managerial responsibility was contradictory to the government intention to restrict medical professional control, through responsible autonomy in a post-bureaucratic NHS. The challenge for traditional bureaucratic organisations with their "consistency of rules, duties and obligations creates legitimacy and accountability" was the "demand for flexibility within post bureaucratic" organisation (Budd, 2007: 540).

With increasing reform intensity the "conflict between management authority and professional autonomy became more pronounced" (Harrison & Pollitt, 1994: 57). To balance this power relationship, Garelick & Fagin (2005: 248) advocate "the restoration of clinical autonomy as opposed to purely market or bureaucratic models, with clinicians is becoming collectively and professionally accountable for the quality and cost of their decision," within a post-bureaucracy paradigm.

Against this background of tensions between doctors and managers over the shift from bureaucracy to post-bureaucracy, or the "demise of traditional bureaucracy and Taylorism" (Maravelias, 2003: 550) was the introduction of performance appraisal by the government. This initiative may be "interpreted as a policy aimed at transferring direct responsibility and decision-making to front-line clinical professionals (Goddard & Mannio, 2006: 67).

3.6 The power of information and the power of knowledge: panoptic surveillance and secrecy

Two driving forces for change are the power of information and panoptic surveillance which are opposed by the restraining forces of the power of esoteric medical knowledge and professional secrecy. These power dynamics may shape the nature of control of medical performance in the NHS. A key question in this NHS study is how power is exercised "concretely, and in detail" (Townley, 1993: 226). In respect of doctors, the sources of their power are manifold. Doctors traditionally "have enjoyed a privileged position and status in society, and their activities have been typically protected or sanctioned by the state" (McKinlay & Marceau, 2002: 381). These authors further considered that, "doctors act as independent agents, free from administrative oversight and with little formal accountability," and that doctors have the privilege of legally sanctioned 'self-regulation' with the acquiescence of government and public.

Power of knowledge

Foucault emphasises the close "connection between power and knowledge" (Foucault, 1973, cited in Townley, 1993: 224). He argued that "there was an inseparability between knowledge and power, the inversion of the 'knowledge is power' dictum to 'power is knowledge'" (Gordon & Grant, 2005: 36). In *Birth of the Clinic* (Foucault, 1973), Foucault argued for a relationship between medical discourses and the exercise of power. For the medical profession, "power is exercised through its intersection with knowledge" (Townley, 1993: 225).

This power led to a monopoly. "According to Foucault, the localization of pathology to specific organs in discrete individuals was possible only through the radical disjuncture between the subject and object of the clinical gaze" that led to medicine being "restricted to a professional elite," (Bull, 1990: 248) based on professional authority. "This transformation of medicine into a monopoly allows it to provide a single authoritative framework for the recognition and treatment of disease" (op. cit.: 248-9). Doctors' power was legitimized by "the institutionalized epistemological charisma of the medical profession" (ibid.) through its altruistic contributions to society (Turner, 1984: 12).

Indeed, "the NHS is commonly assumed to have a conceptual system driven by the Hippocratic ethos, with senior clinicians as the dominant group" (McMaster, 1999: 1146). According to Dimmock (1977: 128), their power is based on "their position within the policy-making structure which, in turn, is derived from the profession's control of medical expertise." As an example, the medical professions have power derived from specialised knowledge, which gives them advantages in collective bargaining for their own interests. Dimmock (1977: 126) argues that "the essence of the services' approach to collective bargaining is a strong belief in the efficacy of industry-wide joint agreements" for pay and conditions.

Power of information

Information here is contrasted with specialised medical knowledge. Information is that which may be readily understood by non-medical managers and might be used to challenge the monopoly power of medical knowledge. Kuhlmann & Allsop (2008: 183) pointed out that, "government-driven managerial imperatives take precedence over claims based on the knowledge and expertise of doctors through various forms of clinical governance," based upon information. Most of the Conservative and Labour government initiatives analysed in Chapter 2 depended upon information, especially patient information, performance measurement, evidence-based medicine and clinical governance. In *Information for Health*

(DoH, 1998b: 9), the prime minister declared, "The challenge for the NHS is to harness the information revolution and use it to benefit patients."

The NHS Plan (DoH, 2000), proposed greater patient power and more information for them necessary to make decisions about their own treatment "and to influence the shape of health services generally" (DoH, 1998b: 9). The performance statistics of different hospitals: "www.nhs.uk will give people all the information they need to make the right choice of hospital for them" (SWSHA, 2009: 1). In *NHS Next Stage Review* (DoH, 2008) there was the proposal that the NHS is legally obliged to publish 'quality accounts' along with financial accounts.

Quality control systems around clinical governance are crucially dependent on "processes for monitoring clinical care using effective information and clinical record systems" (DoH, 1998a: 3.12). The Performance Framework identified in *A first class service: quality in the new NHS* (DoH, 1998a) was designed to facilitate the publication of clinical information, with NICE expanded in 2008 to "set and approve more independent quality standards" (DoH, 2008: 12). Under the heading of 'Increased control' in *High Quality Care for All* (DoH, 2008: 53) a new body, the Care Quality Commission, will have "a stronger focus on compliance and more flexible enforcement power." The appraisal process also relies on information since doctors are required to maintain a folder which contains information about how they practised and this folder would be reviewed annually. Thus the government uses information as a means of control to ensure medical performance.

Secrecy

Secrecy may be seen as a restraining force against the driving force of panoptic surveillance. Derber & Schwartz (1990: 140) point out that professionals use "claims of expertise to win great power over clients." Johnson (1986) attributed professional power to the "nature of the producer-consumer relationship" implicit in the concept of the "dependent patient," achieved by secrecy around medical knowledge by the "language it uses that makes it inaccessible to others" (cited in Blakeman, 2003: 135). This secrecy provided a degree of protection of doctors from medical errors. Previously, medical errors were tolerated by the public, and there was no explicit legal requirement for investigation of professional misconduct, because it was considered a rare event and any investigation needed was conducted in camera, involving few medical professionals.

Indeed, the privilege of legal immunity in medicine existed in Hippocrates' time. "Medicine is the only art which our states have made subject to no penalty save that of dishonour, and dishonour does not wound those who are compacted of it" (Hippocrates,

Vol, II: 263). Hippocrates attributed the low esteem of the medical profession to the fact that it was generally above the law. The physician's behaviour was described as insulated from observation by Coser (1961) for the protection respectively of the subordinate and the superordinate, despite guilty knowledge. She argued that, "insulation from observability is the more rigidly maintained the more vital the potential decisions of the authority holder. Denial of observability to him is a direct function of the amount of power vested in his authority" (Coser, 1961: 35-36).

Panoptic surveillance

Panoptic surveillance may be seen as a disciplinary mechanism in which "hierarchical observation acknowledges that power is maintained through the surveillance of activities [and] normalizing judgment is the practice whereby individuals are required to conform" (Henderson, 1994: 936). This may be seen as a means of overcoming medical secrecy. The work of Townley (1993a, 1993b & 1999) and her interpretations of Foucault are key to the discourse around the power of knowledge (not in the sense of esoteric medical knowledge) and panoptic surveillance. Townley's use of Foucault's principles is best illustrated in her article on their relevance for human resource management (Townley 1993b) in which she explains his mechanisms of power as a property of relations, only apparent when exercised, and based on visibility. She argues that Foucault's view of power informs his concept of power-knowledge expressed as techniques used by governments in managing populations. Foucault argues that if something is knowable then it is manageable and that knowledge is not detached but essential to the operation of power. As Townley explains, "knowledge is the operation of discipline" (op. cit.: 521). Townley uses these Foucauldian concepts in her analysis of employment relationships, the characteristics of which "must be rendered known and articulated before they can be managed" (op. cit.: 523).

Foucault used the concept of the panopticon, which was Bentham's 18th Century prison design that allowed a prison officer to watch all prisoners without them knowing that they were being observed, as a metaphor for the power of surveillance. Foucault saw that its aim was "to induce in the [prison] inmate a state of conscious and permanent visibility that assures the automatic functioning of power" (Foucault, 1977: 201). This surveillance in modern institutions is utilised as a means of control with "its anonymous and continuous surveillance...seen in the articulation of a monitoring role" (Townley, 1993a: 232). Foucault shows that surveillance is not only externally imposed but is internalised. Thus "he who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power" because "he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principal of his own subjection" (Foucault,

1977: cited in Bridge & Watson, 2002: 378). In this way, "the efficiency of power, its constraining force has, in a sense, passed over to the other side" (ibid.).

When Townley (1993a: 226) undertook research based on appraisal documents from 30 institutions, into the imposition of performance appraisal into universities, she saw the move as an imposition of "the jurisdiction of a rational organizational structure" onto a traditionally unrationalised domain. She judged appraisal to be "a managerial activity to be judged in terms of its contribution to organizational effectiveness or managerial control" (ibid.). Principally she saw appraisal as a paper version of the panoptical prison construction. She quotes Foucault (1977) when he describes this tower as housing "the policing functions of surveillance, the economic functions of controlling and checking" (cited in Townley, 1993a: 232). Appraisal, she says, combines knowledge production with power effects. In identifying the monitoring function of appraisal, she recognises that "the individual never knows whether he or she is under surveillance or not. It represents the exercise of control at a distance both spatially and temporally" (op. cit.: 233). She concludes that knowledge about individuals and the work they do "articulates the managerial role as a directional activity" (op. cit.: 236).

However, in 1999 Townley shifts her focus towards resistance to appraisal, following interviews with 28 departmental chairs in a UK university, who declared a reluctance to appraise. She found that chairs thought that appraisal did not address needs and that it was "potentially dysfunctional to effective work management, by oversimplifying a set of very complex relationships (Townley, 1999: 289). She argues that this resistance is underpinned by a "general resistance to formalization which is based on its perceived lack of relevance and satisfaction with informal arrangements" (op. cit.: 290). There was opposition to the rationality of technocratic appraisal where management is "presented with a knowable, standardized, empirically verifiable reality" (op. cit.: 298). But she concludes that this did not indicate that informants were against effectiveness, such as improving teaching in the department. Her main conclusion was the existing systems were sufficient and that adding formality appeared to add very little.

Further, as a means of surveillance, Foucault regards disciplinary practices as both the product and the means of accumulating knowledge which influences the behaviour of individuals (Dandeker, 1990: 24). From this perspective, surveillance seems to have two key features. The first feature is the ability to secure the regulation of behaviour by transforming the relationships between the observer and the observed. Surveillance is organised in such a way that each individual subjected to discipline is "totally seen without

ever seeing, whilst the agents of discipline see everything without ever being seen" (Foucault, 1979: 202). This offers an explanatory account of how such routine monitoring and scrutiny constitute a 'discipline' within medicine (Flynn 2002; Harrison & Dowswell, 2002; Sheaff *et al.*, 2004). Doctors' performance "can be inspected and made transparent to the scrutinisers' gaze" thus ensuring that they "behave as they would if they were to be inspected" (Harrison & Dowswell, 2002: 221).

The second feature is the surveillance system's capability to support the strategies of gaining compliance. Dandeker (1990: 39) claims that none of the strategies of gaining compliance is of much use without the administrative support of such a system. This entails a "means of knowing when rules are being obeyed, when [rules] are broken, and most importantly who is responsible for which." Thus, the surveillance system is about governance without the necessity of direct intervention (Flynn, 2002). In this study, the surveillance system, for example appraisal, might have the "apparatus of bureaucratic control" (Barlow, 1989: 500). As in Townley's 1999 study, many doctors felt that the formality of appraisal added little to the existing systems, with the exception of personal development opportunities.

3.7 Control of doctors by appraisal

The driving forces informing government initiatives to increase their control of the performance of doctors have been seen to be restrained by various means by the medical profession. Imposed appraisal is one of the Labour government initiatives showing the determination of the government to control doctors in the NHS. The ideological motive, according to Garelick & Fagin (2005: 244), in this regulatory approach is "definitely dictatorial" and intends to erode professional power and clinical autonomy. Johnson (1998: 1848) points out that "if self-regulation is to be credible" major changes are needed in the NHS.

Other sectors have traditionally regarded the monitoring of performance through appraisal as one human resource management tool designed for "increased productivity" (Brown & Heywood, 2005: 664), "enabling the organisation to control its employees." (Pym, 1973: 233). Jackson & Schuler suggest that professional appraisal is "based on the judgments and opinions of subordinates, peers, supervisors, other managers and even workers themselves" (cited in Brown & Heywood, 2005: 659). Appraisal systems have been viewed as "significant rhetoric in the apparatus of bureaucratic control" (Barlow, 1989: 500) and are

"concerned with assessing and regulating the human resources of organisations, rewarding what is perceived as successful performance and penalising deviance" (op. cit., 501) as a form of social control. Appraisal in the NHS was taken from practices in other sectors.

In the NHS, the shift from bureaucratic control to post-bureaucracy combined with self-regulated control supposedly modified into responsible autonomy was reinforced by various government initiatives, and made more explicit by measurable standards of performance (Dunleavy & Hood, 1994; Russell & Sherer, 1994; Hood, 1995; cited in Jones, 1999: 164). Major changes were designed to regulate more closely day-to-day practices through cost control and performance appraisal. Levenson *et al* (2008: 12) regard appraisal as a process that "moves the profession away from autonomy and self-regulation over its professionalism, to a position where the key characteristics of professionalism in practice are greater accountability and transparency."

The government has imposed formal appraisals of individual medical professionals in the NHS and these "may alternatively be a control system" (McGivern & Ferlie, 2007: 1366) to ensure that "an employee's behavior is consistent with organisational goals" (Tangen, 2005: 46). This type of self-administered surveillance system is a sophisticated form of self-regulated control rather than internal, group-regulated clan control. "Reflective practice derived from individual expertise and professional consensus, based on expert opinion, is being replaced by critical appraisal and a benchmarking bureaucratic model" (Garelick & Fagin, 2005: 244).

The appraisal process was reinforced by the *Revalidating Doctors* policy proposal (GMC, 2000), which attempted to introduce regulation and revalidation of doctors' performance to change the professional culture and improve health service, in terms of restoring public confidence. The report provided a guide to help doctors prepare for annual appraisal, which might lead to revalidation (GMC, 2000:15-19). All these initiatives add weight to the suggestion that the self-regulation of medical professionals had fundamentally changed (Smith, 1998; Warden, 1998).

Townley's (1993) study of management's functions related to appraisal has provided significant insight for understanding the disciplinary 'power-effect' relationship in the labour process. From a critical management point, she related appraisal to "Foucault's concept of discipline and surveillance" in his conceptualisation of power (Mackey. 2006: 97). Appraisal combines "hierarchy, unilateral observation and a normalising judgment [and] the panopticon has been defined as the principle of disciplinary organisation"

(Townley, 1993: 232). She concludes that the appraisal process is used as a tool that "links to the organisational system of punishment and reward" (Townley, 1997: 267).

But Findlay & Newton argued that Foucault's panopticon symbolic of appraisal "is about more than surveillance since it is not just about monitoring 'sub-standard' performance, but knowing why it occurred" (cited in McKinlay & Starkey, 1998: 214). Townley in a later study of the management of labour process claimed that appraisal is part of human resource practices to exercise discipline, and it "represents the active creation or production of knowledge for the purpose of governance" (Cited in McKinlay & Starkey, 1998: 194). She argues that appraisal is a mode of surveillance, which "turns employees into self-disciplinary subjects of managerial control. From which she claims there is no possible means of escape or possibility of resistance" (Worthington, *et al.*, 2006: 2).

In particular, appraisal seems less powerful a tool than Townley suggests to create the panoptical control effect with the NHS, to fully control doctors' practices. The aim of appraisal is to assess doctors' performance in order to foster their continuous professional development and lead to a process of revalidation of the licence to practice (DoH, 2000). So perhaps the opaque intention about appraisal as a control mechanism such a significant threat to the doctors practices in terms of 'tightening control'. As Foucault (1982: 221) argues, "Power is exercised only over free subjects and only insofar as they are free."

3.8 Conclusion

This chapter has used a force field analysis to relate the driving forces for the government to change the control of doctors' performance, mostly derived from Chapter 2, to the restraining forces used by doctors to preserve their traditional autonomy. The literature has demonstrated the intensifying pressures on the State to increase control over professional autonomy to monitor clinical performance and ultimately to improve healthcare quality and service delivery. The current control mechanisms used in the NHS have been analysed using frameworks and concepts (both orthodox and critical) from Ouchi (1979), Foucault (1973), Parker (2000), Friedman (1977), Dent (2005), Gouldner (1954) and Townley (1993, 1997) to examine their characteristics to understand the dynamics of the improvement of healthcare quality, service provision and delivery, against a background of the intensive organisational changes in the NHS. The chapter also sought to address three subsidiary research questions:

I. Why do doctors want to retain professional autonomy?

II. What control theories can be seen at work in the NHS?
III. What means may doctors use to protect autonomy when challenged by the State?

Why do doctors want to retain professional autonomy?

In explaining their desire to retain professional autonomy, doctors would argue that the Hippocratic ethos has a long history which is embedded in their traditions and professional values, upheld over centuries through the Royal Colleges. The Royal College of Physicians argued that professional autonomy was "designed specifically to assist colleagues in matters pertaining to clinical governance and, importantly, independent of the Trust's clinical governance machinery" (Salter, 2004: 143). The stated purpose of clinical governance was to "bridge the gap between clinical and managerial approaches to the quality of" healthcare (Buetow & Roland, 1999, cited in Callaly, *et al.*, 2005:17).

Doctors might argue that self-direction "enhances commitment, loyalty, and motivation" (Ouchi, 1981: 83) and develops a strong sense of community (Mayrhofer, 1998). Professional autonomy is a network-based regulatory framework based on professional commitment, which reduces transaction costs and dispenses with the need for costly control mechanisms. Commitment, identification, compliance, norms of reciprocity and socialisation render doctors relatively free to control themselves given their role, medical expertise and their value system, which affords them the opportunity to remain self-regulating. Doctors have gained monopoly power from their specialist medical knowledge and appear reluctant to willingly give this up and work against their self-interest.

Self-regulation has been maintained because "medical regulation can only be adequately administered by the professionals themselves" (Salter, 2004: 141). Hart (1997: 266) has argued that the self-management of medical and clinical audit may allow professional groups to "play a more dynamic role in the development of quality standards." He claims that would only be possible were significant degrees of professional autonomy were to be restored. Doctors may argue that their high degree of discipline is derived from peer pressure and that individual interests are optimally served by conforming to the group interests and collective responsibility found in clans. This strengthens goal congruence within hospitals and provides a single legitimate framework within which doctors' work for the good of society as a whole.

What control theories can be seen at work in the NHS?

This chapter discussed the shifts of control methodologies and their relevance to NHS control of clinical performance. Ouchi's theories around bureaucracy, market and clan

controls were found to be informative. The institutional rules of clan, market or hierarchy working together interactively in complex arrangements may prevent closer effective monitoring and control of doctors. The NHS seems to be a hybrid with a blend of impure forms of quasi-markets, quasi-hierarchies and quasi-networks. Concepts and theories around medical cultures were found to be too diffuse to be illuminating, despite *An organisation with a memory* suggesting that "a fundamental culture change is necessary" in respect of reporting, learning and safety cultures. Parker (2000: 230) warned that management of culture "should be treated with extreme caution," and not considered it as a panacea.

Concepts of responsible autonomy (Friedman, 1977), as exemplified by the creation of the position of clinical directors in hospitals, was found to have explanatory powers. It has been shown that clinical directors "maintain the occupational closure of the medical domain" by actually reinforcing "clinical autonomy, and "resist attempts to enhance the managerial control of medical practice" (Kitchener, 2000: 129).

Theories of post-bureaucracy and mock bureaucracy have been able to inform the discussions around struggles over control - for example, the observation that institutional complexity of the NHS control systems could lead to mock bureaucracies, in which the key groups in the organisation fail to accept or comply with the rules (Hynes & Prasad, 1997). In moving the NHS towards a post-bureaucratic organization (Bäcklund, & Werr, 2008; Budd, 2007), the challenge is how to overcome the tensions between a monopoly of specialised medical knowledge power, and the bureaucratic rigidities of management.

Finally, theories around the power-knowledge dichotomy and the use of panoptic surveillance, with its depersonalised and pervasive qualities, to overcome medical secrecy were especially relevant to the discourses on appraisal. Appraisal may shift the medical profession from autonomous self-regulation "to a position where the key characteristics of professionalism in practice are greater accountability and transparency" (Levenson, *et al.*, 2008:12). Townley (1993: 236) implied that appraisal over time was "sedimenting a more hierarchical, centralised and disciplinary model of the organisation" This process may add to the challenge to require changes to the medical profession as part of social changes "in the management of expertise and professional service." (Fitzgerald & Ferlie, 2000: 718).

What means may doctors use to protect autonomy when challenged by the State?

In order to protect their traditional professional autonomy when challenged by the initiatives of both Conservative and Labour governments, doctors may use many of the

mechanisms indicated as restraining forces in Fig. 3.1. For example, using mock bureaucracy, the power of medical knowledge and secrecy with a clan system.

The literature addresses the issue of resistance to such changes as appraisal with its use of modern surveillance, which Townley suggests is not possible. Worthington *et al.* (2006) disagree and cite a range of authors who suggest the types of tactics that may be employed by doctors, such as 'appearance management,' 'playing tick-box games' in their subtle opposition to appraisal. These tactics were apparent from the case study interviews in this research (see Chapter 5). So, it may be that post-bureaucracy has its own counterpart in a mock bureaucracy.

The next chapter will discuss the research methods in this research, explaining how the research was done. It covers the strengths and weaknesses of the qualitative and quantitative research methods in the empirical work undertaken for this thesis.

Chapter 4

RESEARCH METHODOLOGY

Cebes: "Either we were not good judges, or there were no real grounds of belief."
(In "The Essential Plato: Introduction" by Botton, 1999: 636)

4.1 Introduction

The previous chapter reviewed the literature around the tensions between professional self-regulation and the quest for more direct control by NHS management of the performance of doctors. Attention was focused on how doctors have responded to government policies, especially the introduction of appraisal in light of how they perceive the appraisal process and how and why it is viewed as a challenge to traditional professional self-regulation.

This chapter first intends to share some self-reflections on the rationale, methodology and relevancy of this research on the themes of self-construction and self-examination in the narratives of the whole research journey. I intend, via reflection, to give myself a conclusion about what I have leaned about the process of research and what I have learned about myself (Bourner, 1996, Cited in Greenfield, 1996). Yet, for me, the learning curve was steep and it has been a valuable experiential learning journey (Kolb, 1984), learning by doing (Dewey, 1933), being capable of reflecting on my feelings and experience (Schon, 1983). It has not only widened my research world, but personally, it taught me to be capable of exposing my ignorance and to be humble to learn from others. Most importantly, I have gained profound awareness of self deficiencies in conducting and constructing future research projects.

Second, the chapter describes how the research was conducted and critically evaluates the strengths and weaknesses of the quantitative data collection through questionnaires and qualitative data collection by semi-structured interviews. The context of the data collection is significant in assessing its validity. This study is about the control by government of the clinical performance of doctors through appraisal and the doctors' responses to appraisal. The interpretation of the data in this study will recognise heterogeneity and take note of that literature which implies that the current appraisal process in the NHS may potentially increase the doctors' semi-detached power position by further generating intra-professional power shifts. Some of the informants were appraisers and some of these had "hybrid roles

and gained in political power and autonomy are themselves exercising a degree of quality or technical control over other professional colleagues" (Fitzgerald & Ferlie, 2000: 733). The distinction between different grades of doctor (Consultant and Non-Consultant Grades) is identified in the data analysis, since the relative power of the incumbents may colour their responses to the appraisal process, and reflect intra-professional power gradients.

4.2 Self-examination - the problematic of the initial research topic

This section begins by recalling the experience on the problematic tensions there are between personal interests and the reality of the difficulties in gaining access to the research field, particularly in NHS hospitals. These experiences required the researcher to examine the research methodology and review the research questions, including the decision ultimately to withdraw this project. It was then necessary to reshape the research direction in terms of fitting it to the available research data.

The proposal - a pie in the sky

The research proposal is an important part of any research project. In addition to it being conducive to maintaining a research direction, it also helps research programme implementation and verification as the basis for the whole research process. For the researcher, the research proposal is a statement of "the learning contract" (Saunders *et al.*, 2003: 28). Retrospectively and more theoretically during the initial stages of my formulation and clarifying process, there were two different topics generated and seven versions of research ideas were refined. The finalised proposal was dated February 2003. A working title was given as "Adverse events in the United Kingdom National Health Service (NHS): A study of organisational dysfunctionality".

Although it has not much relevance to my current research topic, it has contributed to a great extent to the theoretical formulation and methodological construction in my later research subject. Nevertheless, both the original and current topic were intended to study organisational management, which "deals fundamentally with the production and legitimating of the various forms of knowledge associated with the practices of management" (Partington, 2002: 1). The aim of this earlier research was designed to investigate front-line medical staff perceptions of culture problems related to adverse events in the NHS. The key concern of this topic was to assess to what extent organisational dysfunctionality could contribute to the reduction of medical errors and adverse events.

The topic interested me since at that time medical adverse events were discussed intensively in the media and by the public, due to the exposure of a series of medical professionals' misconducts (Sitford, 2000; Kennedy, 2001; Toft, 2001; Smith, 2000-2005; Redfern, 2001; Ritchie, 2000; Matthews, 2004; Pleming, 2005). Also, my personal medical educational background and my professional conscience encouraged me to seek solutions to those problems. And more, my personal understanding was that such a topic had a strong theoretical foundation, which could provide a clear context for the research (Drummond, 2000), as it might involve broad social sciences concepts, for instance, organisational behaviour, organisational culture, power, control and professional regulation (Meyers, 1987; New, 1993; Newdick, 1995; O'Leary, 1996; Schultz, 1995; Schein, 1983;1985; Runciman, et al. 1993; Rosenthal, 1995; 1997; Parker, 2000).

When the topic was confirmed in the early stage of the study, I under-estimated its feasibility with such problems as time constraints, financial hardship and the most frustrating aspect that emerged while undertaking this project was the problem of data collection. This became my main worry during the research journey. Because, at the beginning of the research plan, there was a promise of help for me to gain access to this research field. According to Drummond's (2000: 311) golden rule, "The fewer dependencies, the lower the risk." So, I put my project at high risk at the beginning because the project itself had to rely on other people's connections into the research field to undertake data collection. I was anxious and worried intensely, "How /where exactly can a specific group of respondents be located?" During the months waiting for the 'promised access' to happen, I failed to make contingency plans for an alternative access to data in case of a break-down at the beginning of the study.

Behind those anxieties and worries, lies a cultural barrier in my 'powerless' position as a student. I brought up in China, and the culture etiquette as a student, is that we obey our superiors in the decision-making process. In my case, the expert power of my superior, which had often influenced the decision making process, also gave the superior the power of control over the alternatives considered (Pfeffer, 1982). From my position, it was also accompanied by a great degree of trust in my superior's expertise in the research field. Therefore, the initial research strategies were very ambitious, intending to apply case studies, questionnaires, participant observation and structured interviews, as I believed that such strategies would allow me more control over the research process. Nevertheless, I was not aware that a survey strategy can be time consuming. I also under-estimated the delay of progress which could result from relying on others for information.

After the long-awaited help from others failed to materialise and my project's time pressure increased, I realised that I had responsibility for my own research project. I started the journey to fight for a 'green light' for my field study by myself. I recall this as a valuable learning experience for me, since "experience alone can teach us the measure of our powers; and if men had not begun by an exaggerated estimate of what they can do, they would never have done all that they are capable of" (Martineau, 2000: 30). In the next section, I will narrate the journey through the negotiations to gain access to the research field, which in my study are NHS front-line medical professionals in hospitals.

Methodology dilemma - fight for the 'green light'

Any research projects should consider the methodology. Whatever the nature of our enquiry and whether we attempt to be quantitative or qualitative, we should be systematic. Guidance is given by Mason's (1996: 20–21) questions on data collection methods:

- *What data sources and methods of data generation are potentially available or appropriate?*
- *What can these methods and sources feasibly tell me about? Which phenomena and components of social 'reality' might these data sources and methods potentially help me to address (ontologically)?*
- *How or on what basis do I think they could do this (epistemologically)?*
- *Which of my research questions could they help me to address?*

In May 2004, I personally tried out the pilot questionnaires by post to four local hospitals and eight questionnaires electronically, without any prior contact to the Trusts. None was returned from the 40 questionnaires sent by post and there were only two returns electronically. Reflecting back on this failure, it was that I lacked awareness of the importance of ethical approval at the beginning of any research project and I lacked experience in research procedures. I was very distressed at the time when I had a response from the Royal Liverpool Children's Hospital, which advised me that I had to follow formal procedures in terms of gaining access to conduct my research. In particular, The Central Office for Research Ethics Committees (COREC) had introduced a new electronic form for applications to the Research Ethics Committees (REC). From then, I started the process of applying through the North West Multi-Centre Research Ethics Committee, The Central Office for Research Ethics Committees (COREC), Local Research Committee and eight local hospitals' Research and Development sections.

There were four hospitals that were willing to consider my project, but since my study intended to investigate how organisational dysfunctionality contributed to adverse events, looking particularly at organisational culture, behaviour and NHS control policies, which might be "potentially threatening for the trust." (Quotation from notes taken in the conversations with the Trust R &D managers). So, the project itself was not very popular compared with an investigation into a medical product or medical device in a study, which might have "immediate benefit" (Quotation from notes taken in the conversations with the Trust R &D managers) for the hospitals during the study. And more, medical adverse events had been highlighted after the Bristol Royal Infirmary Inquiry (2001), the Alder Hey Inquiry (2001) and the Shipman Inquiry (Smith, 2002-2005). Following these, various intensive surveys within the NHS hospitals, both from government bodies and non-government bodies to scrutinise doctors' behaviour were undertaken. The environment within the hospitals appeared "cautious" and "paranoid" (Quotation from notes taken in the conversations with the Trusts' R &D managers) towards any outsiders who were suspiciously scrutinising them.

I did, however, obtain four hospitals' interest as potential field study sites. However, according to advice, I needed to set this project up formally at the Royal Liverpool Children's Hospital through its research committee approval process as it was the leading hospital in my project. I needed to apply for an Honorary Research Contract (HRC) within these four hospitals since, without this contract, the hospitals' R & D managers could not 'circulate' the questionnaires for me. In order to gain these contracts, the COREC, LRC had to approve the project first, and the project needed approval by the four selected hospitals' research committees as well. The main supporting documents for the process included the research protocol, the sample questionnaires and the sample interview questions. Also, I needed to have evidence of a Criminal Record Background (CRB) check being issued within the last 18 months.

The work on the approval processes lasted until April 2005. Within these periods, there were over one hundred emails, letters and telephone communications between the four selected hospitals' gate-keepers and their R & D managers. The negotiation processes centred on concern with my research protocol, the questionnaires designed and the interview questions. I had consistently amended the approach according to their suggestions. There was progress, but it always one-step forward and two steps backwards. Sometimes, I thought I saw a 'green light,' but I underestimated the applications' complexity and demands. Also, COREC kept upgrading its application form, which added more stress on me in order to supply more documents to satisfy the Trusts' Research

Review Committee's requirements. As they admitted, the ethical approval is getting 'strict' and 'tough' regarding the research intention to conduct in hospitals after the exposures of the series of professional misconduct cases in the NHS.

The originally designed questionnaires were supposed to reference the Commission for Health Audit and Improvement (CHAI) 2004 NHS staff survey questionnaire as a framework, according to my superior's suggestion, but I found out that the CHAI questionnaire questions were not relevant for the subject matter of my research. So, I was trying to design my own questions, but I neglected to adjust the terminology to fit the NHS style. Such a problem was pointed out by some of Trust R & D managers, who suggested the solution could be the use of a "validated questionnaire with an established track record." The more often a questionnaire is used (provided that results always appear to be consistent) the more reliable it can be assumed to be because it has a track record, for example, the CHAI survey. (Emphasis from notes taken from the correspondence with the Trusts' R &D managers).

In respect of my own design of questionnaire, I have included in my research protocol some provision for 'piloting' it by checking that the questions were understandable by my target audience and not ambiguous or biased. One of the R & D managers advised me that "the validity of questionnaire may take several attempts to get right" (Quotation from notes taken in the conversations with the Trusts' R &D managers). However, as a fact, I did adopt a few questions based on the CHAI questionnaire, which raised another concern pointed out by one of Trust managers that, "pick and mix questions from different questionnaires without careful thought, the questions asked in different contexts can produce completely different responses." And the manager also implied that this mean that "a validated questionnaire is validated as a whole, not as separate questions" (Quotations from notes taken in the correspondence with the R & D managers from the Trusts).

The other arguments suggested that using a validated questionnaire, such as CHAI form "will make your application much more likely to succeed." This was because it could secure what I sought in "language that has already received Ethics Committee approval at the national level. Our Ethics Committees is pretty 'tough' on staff questionnaires, particularly where there is any perception of 'consequences' to staff if they answer wrong questions, and so I would advise you to use 'approved' language and levels of information about individual respondents, bearing in mind that even the CHAI questionnaire is reviewed with considerable suspicion here." (Quotation from notes taken in the conversations with the Trusts' R &D managers)

Another Trust manager told me that their most recently circulated questionnaire at the hospitals on behalf of CHAI – effectively "mandatory", yet the response rate was less that 40%. One of the major reasons for not returning the form is that staff feel that they may actually be identifiable through the questions asked, even though there is a categorical statement of confidentiality. More, even one Trust manager declared that "having just done the CHAI thing, no one here will be keen on doing another "long" questionnaire with multiple-choice answers –"yes" or "no" is about our limit of co-cooperation." One Head of Staff Development from the Trust, who indicated that for surveys such as my project, "a return rate of around of 5-10% is typical for non-Government surveys amongst NHS staff." (Quotations from notes taken from the correspondence with the R & D managers from the Trusts).

The implied advice to use approved language caused some degree of anxiety to me. I must very carefully choose the wordings, in terms of the survey context, and try to avoid threatening phases. However, some of the issues I wished to explore could not be made 'more sensitive' in their wording. The problems of my research protocol, questionnaires and interview design were identified. I had amended the questions accordingly to the Trust managers' requirements. Only in its fourth version did the RLC showed some satisfaction. The questionnaires had been repeatedly changed, and the seventh version was finally allowed to be piloted within the four selected hospitals. This was a very encouraging stage for me, as I thought that I had almost succeeded in gaining the golden key for access to the research field. Then a new issue cropped up that turned the whole process back to square one. The next section will explain the rationale of withdrawing the project and shifting the research direction.

Withdrawal of the project – turn to the new direction, new challenge

By April 2004, the struggle with ethical approval had shown positive progress, and particularly, the site ethical review provided positive feedback, after the seventh version of the questionnaire had been piloted in the four selected hospitals. I had officially received one formal one year Honorary Contract, and two informal Honorary Contracts from the hospitals. While I was amending the questionnaires according the feedback form that was piloted, my visits to the hospitals were in the process of being arranged. However, without CEROC, LRC and RLC approval and hospitals site assessments, I could not circulate any questionnaires or interview any medical professionals.

Then I was asked to provide "insurance or indemnity cover," which has to come from the University Research Ethical Committee, but I was not even aware that I had to go through this procedure. In fact, both my supervisor and I had believed that as my research was not focused on patients, then that ethical approval was not required. Unfortunately, your connections or who you know inside the organisation does not work now. The new policies require that any research undertaken within health care settings need ethical approval and the forms have to be completed by the researcher personally. In order to satisfy the Trusts' REC requirement, I had go back to the Management School to submit my research protocol to the University REC to gain their ethical approval first, which might well have take me one to two months to have the results. If I had been able to prepare all the supporting documents, to resubmit my application form to Central REC, LREC and the RLC hospital (which was leading the ethical review), then it would have taken about 60 days for all parties to finish this review. Even that "does not mean you might succeed in gaining ethical approval in the end" (Quotations from notes taken in the correspondence with the R &D managers from the Trusts).

Having faced the time constraints, and with my project barely having started, after eighteen months of seeking approvals, I was in a panic and stressed because, according to the research proposal, I should have been at the writing-up stage by then. I recognised that there was no way I could avoid those bureaucratic processes, I had to reconsider my timetable and my research methods. This was a student project, and I could not be too ambitious. I did not have the time or the resources to continue fighting for this demanding ethical approval any longer. But where should I go from here? Can this situation be justified? With so little time left, what methodology I can choose?

My current supervisor intervened and recommended that I should use a group project from which the data might help me to interpret some of the research questions that I wanted ask. But there were significant concerns on this available database. First, because it was originally designed as an attitude survey with doctors about appraisal, which might have little intrinsic value for my original research framework. Second, as a group project, I was not personally involved the questionnaire and interview design processes. Therefore, I missed the opportunities to appreciate the methodological rationale within these practices. Third, I was facing a dilemma between personal integrity and academic integrity in handing this database. On the one hand, I do need such a database, but on the other hand, I was not sure of its absolute integrity or its legitimacy. After obtaining official approval from the Head of Department and the Head of Research, I took this group data set as empirical work for my thesis.

However, because this data set at times lacked relevance with my already well-established framework, the new challenge was how to make this obliquely relevant database useful, I had to reshape my methodology and all my research questions, in terms of fitting them into the available data resources. Hence, the final research topic intended to look into the attitude and responses of medical professionals to government policy – appraisal and its potential function as a control mechanism imposed in the NHS, in terms of guaranteeing healthcare quality and improving medical performance. Even, having related appraisal to organisational control theories, such as clan control, the data appeared rather limited, for example, for exploring the ways in which clan control prevents surveillance.

Given the opportunity of time and available resources, the research could have overcome its current limitations, in terms of questionnaire and interview design strategies. For example, the issue of lack of comparisons in the data concerning different groups could have been rectified if the questionnaire had been designed using a Likert scale. This would have opened up two or more related variables for comparing the same phenomena. The lack of material reflecting managerial perspectives on clinical performance might have been overcome by the use of participant observation, adding validity to the data. Therefore, sensible and rational treatment of the existing data was the key challenge for the researcher in this study.

The journey of this methodology process was a very comprehensive experience and an important learning process for me as well. Kolb (1984: 39) argues that "the process whereby knowledge is created [is] through the transformation of experience." After many years of juggling with different projects, I gained a great deal academically and personally. It has made me more self-confident and self-reliant, with wider applicability both in sociology and in other fields of study. For example, it showed me how to design and conduct a survey and to discover my ignorance of the detailed research processes. It also gave me great strength in facing adversity, and I have gained more confidence in dealing with different people and different problems within the research context. To some extent, I think I have learned to appreciate the basic principles and the rigour of methodology in the social sciences. The next section will outline the methodology finally applied to the current research topic.

4.3 Methods of investigation and methodological paradigms

The question of the flexibility available to the researcher in conducting his or her research project is one of crucial factors to consider in choosing whether to use a qualitative or a

quantitative approach (Stake, 1995). Oxley (2001: 104-105) argues that "It is the purpose of the research that should drive the method." This study applied both quantitative (questionnaire surveys) and qualitative (semi-structured interviews) methodologies for the collection of data. The "main feature that distinguishes qualitative from quantitative research lies in the nature of the data derived and the analytic process associated with it" (Miles & Huberman, 1984: 43).

These research methods have traditionally been associated with different epistemologies and the different paradigms, for qualitative and quantitative studies imply different philosophical or methodological explanations of particular research questions. And, therefore, different research approaches depend upon the way that the researcher thinks about the development of knowledge. In other words, it is about how we are doing research. The qualitative approach may reflect an interpretative position (the inductive), whilst the quantitative approach suggests a positivist stance (the deductive), "to develop valid and reliable ways of collecting 'fact' about society, which can then be statistically analysed in order to produce explanations about how the social world operated" (Clarke, 2001: 32).

However, there has always been a conflict between positivist and interpretativist, approaches, "which defends the particularity of human sciences in general, and organisational science in particular" (Thietart, 2001: 14). Saunders, *et al.* (2003: 85) viewed the positivist and interpretative labelling as "potentially misleading and of no practical value." York & Clark (2006: 157) note that contemporary social research is "essentially pluralistic; researchers often combine quantitative and qualitative research methods within the same study." The "information provided by qualitative case studies can be used to illustrate, explain and add depth to the findings of quantitative research" (Adcock & Collier, 2001: 35). This has been done in this study.

It has been observed by Clarke (2001: 32) that the positivist tradition or quantitative methods find "most support in policy-making circles. Policy-makers want information to help them to make rational decisions." York & Clark (2006: 105) view "quantitatively oriented researchers as helpful technical experts having the necessary skills in statistical analysis to produce accurate, objective and scientifically valid analyses of" and "the nature of social problems and the impact and effectiveness of policy solutions." Nonetheless, Silverman (2000) argues that methods of research used by social scientists must be able to document adequately the richness and diversity of meanings people attribute to phenomena. They must enable us to document the ways in which meanings are constructed and negotiated within particular social contexts and become regarded as taken-for-granted.

From this stance, quantitative and qualitative methods, jointly forming mixed-method research strategies, "have important parts to play in policy research" York & Clark (2006: 72). The mixed-method research strategies can be used to highlight different dimensions of problems (Clarke, 2001). Stake (1995:37) suggested three major differences between quantitative and qualitative:

- *Between explanation and understanding*
- *Between a personal and impersonal role for the researcher*
- *Between knowledge discovered and knowledge constructed*

The distinct epistemology of the two methods will be explained below.

The strengths and weaknesses of quantitative research

Quantitative research reflects the philosophy of the relationship between a number of variables and is the positivist paradigm (Bryman, 1988, 1989; Stake, 1995; Silverman, 1993). In other words, it searches for a cause, for an explanation, in terms of understanding, to identify the cause and effect relationship within particular complex social phenomenon by collecting numbers, "which can be statistically analysed, to produce explanations about how the social world operates" York & Clark (2006: 76). Many forms of behaviour and social phenomena can be similarly quantified by rating scales or numerically measurable research questions (McQueen & Knussen, 2002).

The strength of quantitative research is influenced by its philosophical epistemology, founded on positivism which is "the scientific method to all forms of knowledge and gives an account of what that method entails, divergent versions notwithstanding" (Bryman, 1988:14), and the aim of positivism is to "explain reality" (Thietart, 2001: 14). For example, quantitative researchers "seek to absorb the methods and assumptions of natural scientists which have tended to be interpreted in positivist terms" (Bryman, 1988: 34) and some distinct features of positivism are suggested by Blakie (1993) and Giddens (1995):

- *Emphasis on prediction and discovering general laws*
- *Society is based on laws which can be discovered with the aid of science*
- *Emphasis on explanation*
- *Society can be taken at its face value*

Those features imply that the nature of quantitative methods is likely to centre on general principles in hypothesis and theory, or, in other words, from general principles to observation of empirical data. On this point, Bryman (1988:16) has argued that, "there is a sharp difference between theory and observation. Empirical verification is taken to entail devising observations, which are independent of scientific theories and hence neutral. Observations are viewed as uncontaminated by the scientist's theoretical or personal

predilections." Yet, the philosophical origin of positivism is related to rationalism, which is based on deduction, whose epistemology of knowledge comes from discovering fundamental laws. Bryman (1988: 21) notes the key problem in qualitative research is the "relationship between theory and data."

The questionnaire survey in this study was adopted to address the research questions outlined in Chapter 1, to investigate mechanisms, formats, functions and the administering control of medical performance, as exemplified by appraisal. For example "Are you aware of the aims and objectives of annual appraisal?" Secondly, the questionnaire explored how the process was implemented and received. For example "Did you find the appraisal to be a positive experience overall?" This is more in the positivist tradition. Such methods "look for the existence of a constant relationship between events" (Robson, 2002: 21). According to May (1993: 5) "the predication of the behaviour of phenomena, explanation of the behaviour of phenomena and the pursuit of objectivity, [which] is defined as the researcher's 'detachment' from the phenomena under investigation" and he further claimed "in this process, position explains human behaviour in terms of cause and effect." Therefore, it requires that the researcher "seek primarily to *understand* and *explain* observed organisational phenomena by developing a theory around it" (Chia, 2002: 3: emphasis in the original).

Within the positivist approach, the researcher is seen to maintain "an objective stance by the use of research tools and methodologies such as questionnaires to serve to safeguard against bias by limiting the amount of personal contact between the researcher and the research." The weaknesses of quantitative research lie in the central philosophical assumption "that there exists an objective reality or 'truth,' which can be measured by scientific investigation" York & Clark (2006: 76). This has led to critics arguing that quantitative research "ignores the differences between the natural and social world by failing to understand the 'meanings' that are brought to social life" (Silverman, 2000: 4-5). In the context of this study the main issue is whether this research tells us anything about the NHS as a whole. It may be that it simply gives us a partial insight that may be essentially different in different areas and among different groups. Thus a major limitation of this research is the lack of comparative data concerning these different areas and different groups.

The data sets

This research consisted of two sets of data, one regional and one national. The research focused on Consultant Career Grades (CCG) and was confined narrowly to the Northern

region, in the Merseyside and Cheshire Deanery, which covers the Merseyside and Cheshire NHS Trusts' hospitals. There were 1143 questionnaires distributed to CCG consultants and 417 of these were returned, representing a 36.48% response rate. Of these 134 had also acted as appraisers. Yet, the researcher hoped to generalise the result to the population from which the sample had been taken. The researcher "must apply statistical generalisation" to generalise results from these sample groups (Thietart, 2001: 216). One of the concerns was whether the degree to which the results drawn from such a sample applied in this study could be applied to the whole population. Or "To what degree these results can be compared to the norms or standards generally accepted about this population?" Thietart (2001: 216).

The national study focused on Non-Consultant Career Grades (NCCG); 5050 questionnaires and 1432 of these were returned which is a 28% response rate and lower than that from the Consultant grades. According to Saunders, *et al.* (2003: 87) "to generalise about regularities in human social behaviour it is necessary to select samples of sufficient numerical size." The researcher has to be aware that research into such a particular population would only allow inferences to be made about that particular population, and "it would be dangerous to predict" that such a population response about the appraisal could cover all medical professionals in the NHS Trust hospitals (Thietart, 2001: 87).

Response rates from surveys in the NHS may be compared to these results. One Trust manager discussed a recently circulated questionnaire at the hospital on behalf of the Commission for Health Audit and Improvement which was *"effectively 'mandatory,' yet the response rate is less that 40%. One of the major reasons for not returning the form is that staffs feel they may actually be identifiable through the questions asked, even though there is a categorical statement of confidentiality.*" This raises the question over the reasons for low response rates to NHS questionnaires.

The strengths and weaknesses of qualitative research

Qualitative research questions are oriented to looking for patterns in cases or phenomena, unanticipated as well as expected. It seeks personal interpretation and explanation rather than causal explanation (Cook & Reichardt, 1979). It focuses on specific phenomena of human activity, with an emphasis on words rather than numbers (Miles & Huberman, 1994; Maxwell, 1996; Stake, 1995; Silverman, 2000; McQueen & Knussen, 2002). "A central theme in the qualitative perspective is the emphasis placed upon 'naturalism' (Yvonna & Guba, 1985: 56). In its widest sense naturalism maintains that social phenomena are distinct

from physical phenomena "in such fundamental ways that they cannot be understood by applying scientific methods and methodologies from the physical sciences" (Yvonna & Guba, 1985: 71).

Hence it is "the task of sociology to reduce these concepts to 'understandable' action that is without exception, to the actions of participating individual men" (Gerth & Mills, 1946: 55, cited in Wagner, 2003). Karl Mannheim (1936, 1940) considered that the "problem of interpretation took a formidable turn toward the 'sociology of knowledge'"(Science Encyclopaedia: Science & Philosophy, 2008). For him, all knowledge was partial knowledge. "Mannheim's sociology of knowledge insisted that cultural views - statements, beliefs, values, literary productions, and so forth - always bear the stamp of their context" (Science Encyclopaedia: Science & Philosophy, 2008). In this sense, interpretive research acknowledges, and even welcomes, the involvement of the researcher in the process of data collection and analysis.

One of the strengths of qualitative research is the employment of documentary evidence, which has the benefit of not requiring access to managers within the organisation (Harrison, 2002: 189). For example, in this study, the research has used documentary evidence to look at some qualitative data in the literature review (see Chapter 2). Consultation documents, White Papers, legislation and GMC publications between 1979 and 2008 were used in this research because they have been the principal source of government guidelines and protocols employed directly or indirectly in shaping the current NHS's organisational control systems and have influenced the doctors' attitudes towards managerial control in the health service.

There were intensive policy reforms during this period. One main driving force behind these policies was the government's response over recent years to "a series of highly publicised examples of errors and unacceptable medical practices occurring within the NHS" (Worcestershire health, Annual Health Report: 2001: 48). They "shook public confidence in the NHS and acted as a major stimulus for the clinical governance initiative introduced by the Government to tackle these failings" (ibid). Also, these particular documents were selected because they comprehensively reflect how government policies evolved according to their different ideological contexts and driving forces for reform. The political interests and ideologies of Conservative and Labour governments and their subsequent reforms are assessed with respect to their impact on patient safety, clinical performance and professional autonomy.

Another qualitative method used in this study was non-standardised interviews, which has strengths as "a way of getting close to the data and studying social interaction in its natural surroundings" (Clarke, 2001:33). Theory building in this study from the inductive approach angle is to "follow data rather than vice verse as in the deductive approach" (Saunders, *et al.*, 2003: 87). Stake (1995: 23) considered that qualitative research is concerned with personal interpretation and explanation rather than seeking cause and effect explanations. Stake (op.cit.: 39) explains that qualitative research "tries to establish an empathetic understanding for the reader," and for the qualitative researcher "the understanding of human experience is a matter of chronologies more than of cause and effect." In other words, they are intended to seek understanding of complex interrelationships through non-standard interviews.

Other social scientists, for example Bryman (1988: 49-50), see "qualitative research as an approach to the study of the social world which seeks to describe and analyse the culture and behaviour of humans and groups from the point of view of those being studied." He goes on further, describing qualitative research as "being predicated upon a prior set of assumptions about study of social reality." Therefore, the qualitative researchers are likely to see social reality from their own position within the world. Nevertheless, one of the strengths suggested for using qualitative research is that it allows the researcher to discuss the views of the research participants and to reflect on the influence of their own social position on their perspective of specific events and attitudes (Bryman, 1988, 1989; Hertz, 1997).

The researcher treats research as a social activity during which researchers and research participants produce an account that is context specific (Whyte, 1981). The researcher also believed, "We have motive enough in the hope of discovering the laws of phenomena, with a view to the confirmation or rejection of a theory" (Martineau, 2000:30). Schwandt (1994) emphasised the holistic treatment of phenomena as the distinguishing characteristic of qualitative research. The centrality of interpretation is the primary characteristic of qualitative research (Erickson, 1986). The same argument can be found in Bryman (1989), who points out that participant observation and unstructured or semi-structured interviewing are the most prominent methods of data collection in qualitative research. These techniques demonstrate that qualitative research "tends to be unstructured in order to capture people's perspectives and interpretations" (op. cit.: 25). The nature of these relevant techniques applied in this study will be discussed later in this chapter.

There are weaknesses in qualitative research summarised by Stake (1995: 43) as follows:

- *"Qualitative inquiry is subjective*
- *Its contributions to disciplined science are slow and tendentious*
- *The results pay off little in the advancement of social practice*
- *The ethical risks are substantial*
- *Time consuming and costly"*

The last problem of qualitative research, needing to be addressed in here, is the difficulty of replicating its findings. This is one of the arguments against qualitative research by exponents of quantitative research. For example, Bryman (1988: 38) argues, "It has an intuitive component and is seen as a product of the idiosyncrasies of the researcher."

The questionnaires included some 'qualitative' questions such as:

> *30: Do you feel that the appraisal process will effectively support the validation process?*
> *31: If your answer to question 30 is No, please state the reasons for your answer.*

Where the answers to such questions seemed insightful, the respondents were asked if they would be prepared to give an interview. Fifteen follow-up interviews were conducted with Consultant Grades, which represents a sample of 3.5% of the 417 doctors who returned the questionnaire. Of the 1423 questionnaires returned form Non-Consultant Grade doctors (832), staff and Associate Specialists (591), 32 volunteer respondents from NHS Trusts in the North West, Midlands, South West, South East and London were interviewed. This represents a sample of 2.2%.

However, this study has applied both qualitative and quantitative methods, namely, questionnaires and interviewing in the data collection and analysis processes. The qualitative data in this study fall into the category of subjectivist and interpretive. The perceptions of different grades of doctor around appraisal have been explored. The next section examines the technical issues about those methods and their limitations in relation to this study.

4.4 Data collection

In the last section, the researcher discussed the nature of qualitative and quantitative research methods by mainly looking at their different philosophical and epistemological foundations, from a social science point of view. The researcher believes that by employing "both quantitative and qualitative methods for collecting data, the findings are likely to be more convincing and reliable if the analysis is based on several different sources of evidence" (Silverman, 2000: 39). In this section, the researcher intends to address a variety of qualitative and quantitative methods of data collection in this study and the rationale for employing those methods, with their strengths and weaknesses. In doing so, the researcher

will clarify the different methods from the perspective of the practicalities of conducting this research.

The empirical evidence in this study is derived from questionnaire surveys and semi-structured interviews, which were adopted to investigate the research questions. Fig. 4.1 indicates in green those preliminary questions that have been mainly addressed in Chapters 2 and 3. Nevertheless the evidence here will relate the literature in those chapters to the data. However, the main questions to be answered through the interrogation of the data will be those highlighted in yellow:

IV. Does appraisal appear to be implemented successfully?
V. Is appraisal being used as a control mechanism by the government?
VI. How far do doctors believe that it is possible to control doctors, given the nature of their work?
VII.

The data will also contribute to addressing the research aim:

> *To what extent is the government able to control the clinical performance of doctors in the NHS through appraisal?*

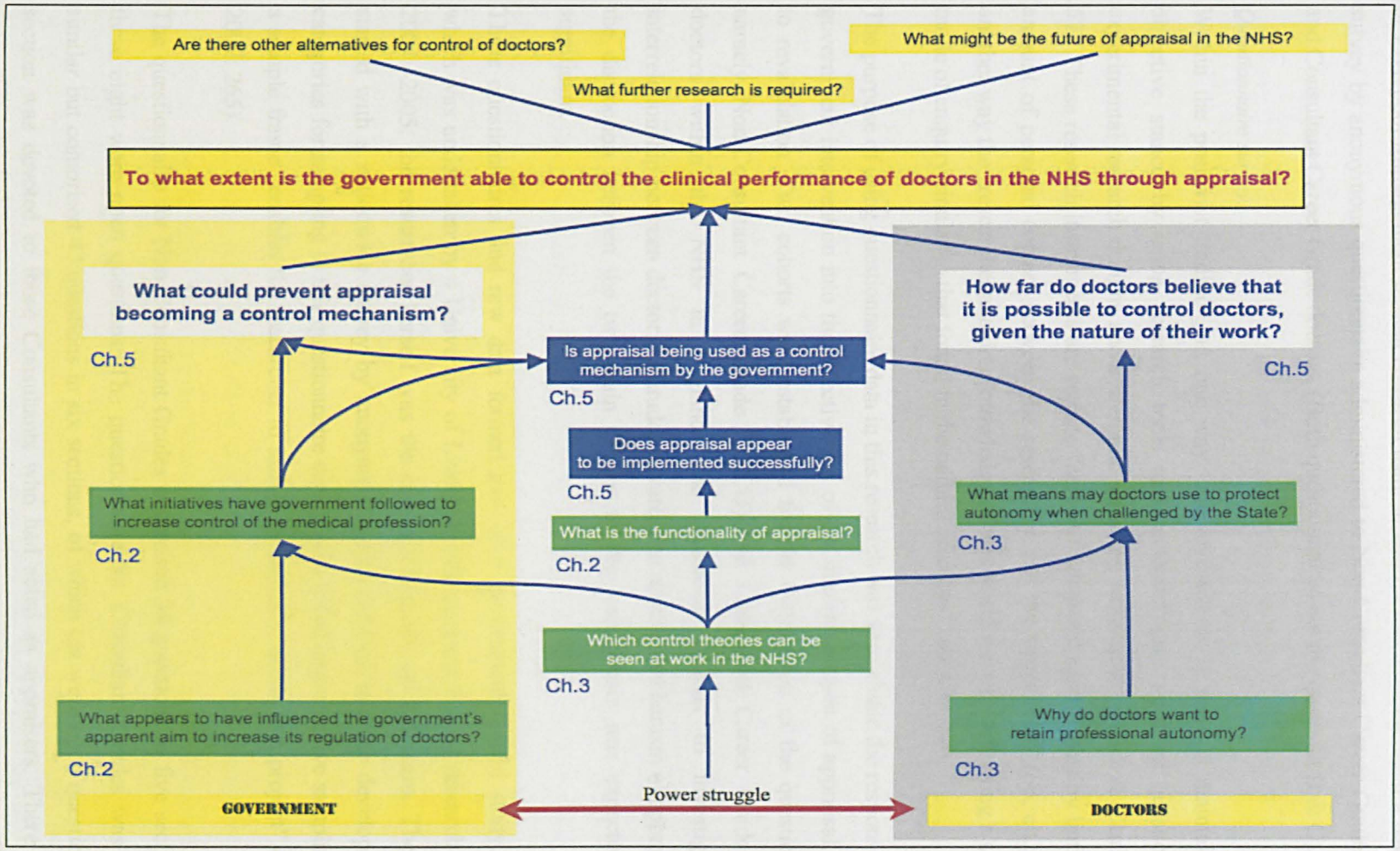

Fig. 4.1 Progress in addressing the research questions (Format from Kirkham, 2009)

In order to evaluate the effectiveness of government control of clinical performance through appraisals within NHS Trusts, a government-funded project was undertaken by a University of Liverpool Management School research team in 2004-2005. This included a nationwide survey by anonymous questionnaire administered to Non-Consultant Career Grade doctors and Consultant Career Grade doctors. (Both questionnaires are in Appendix B & C).

Questionnaire survey

Within the positivist tradition, in one way "the investigator is seen as maintaining an objective stance by using research tools and methodologies such as questionnaires, experimental research designs and systematic sampling techniques" (York & Clark, 2006: 57). These research instruments are seen to "serve to safeguard against bias by limiting the amount of personal contact between the researcher and the researched" (op. cit.: 56). In another way the "researcher acquires knowledge of this world through following a scientific mode of enquiry similar to that found in the natural sciences" (op. cit.: 56).

The purpose of using questionnaire data in this research was to evaluate the responses to the government intervention into the effectiveness of the implementation of appraisal, leading to revalidation. Two cohorts were established for the distribution of the questionnaires, namely Non-Consultant Career Grade (NCCG) and Consultant Career Grade (CCG) doctors within the NHS in England. The researcher intends to investigate the interrelationship between doctors' attitudes towards the control mechanism of appraisal and the distinction between the two main Grades of the respondents was expected to be significant.

These questionnaires and raw data formed part of a government-funded study project, which was undertaken by a University of Liverpool Management School research team in 2004 -2005: the researcher herself was the research assistant of this team. The project started with a nationwide survey by anonymous questionnaires, and the development of categories for sampling in this questionnaire survey was based on purposive sampling; such a sample frame "enables the researcher to satisfy her specific needs in a project" (Robson 2002: 265).

The questionnaire for Non-Consultant Grades comprised 38 questions in five sections. Of these eight were open questions. The questionnaire for Consultant Grades was broadly similar but comprised 43 questions in six sections, of which ten were open questions. One section was devoted to those Consultants who had acted as appraisers. There was no compulsion to return the questionnaires. All questionnaires end with a request for volunteers for interview:

Would you be prepared to take part in a brief face-to-face, telephone or email interview to allow us to explore your views and experience of appraisal in more detail?

The main focus was on how the doctors perceived the implementation and practice of appraisal, and how they responded to the tightening of professional control mechanisms. This was not a direct investigation of the organisational change intended by the recent government initiatives. However, by looking at the attitudes of the responders towards the appraisal process and its links to revalidation, it was intended, via the practice of appraisal process, to understand the possibility of achieving some organisational changes within the NHS.

While designing the questionnaire forms, prior to piloting, the research team sought information from different sources to inform, advise and comment on the design. These sources included relevant literature, relevant national and local documentation regarding the purpose, philosophy and processes involved in the appraisal scheme. For example, '*Appraisal for Consultants Working in the NHS*' (DoH, 2000; Winearls, 2001), and '*Annual appraisal for non-consultant career grade doctors'* (DoH, 2007). The research team also tried to ensure that professional advice and opinions were incorporated into the design by discussing it with Consultants at regional conferences and seminars, and taking advice from the National Appraisal Steering Group special working party. This process generated invaluable feedback, which was used to reformulate the final questionnaire form.

Yet, the extent to which questionnaire surveys are good measures relate to the degree of question reliability (Sheatsley, 1983: Fowler, 1995). However, aware of this possible flaw, Eades *et al.* (2006:11) points out that this questionnaire's design "invited respondents to give negative" comments. So, the emergence of concerns from the open-ended questions might suggest the beneficial use of interviewing in order to enhance the validity of the information obtained. The next section discusses the techniques of interview.

Interviews

The interview is the method to collect data through direct verbal interaction between individuals. For example, in-depth interviews provide data, which give fuller expression to the informant's view. Four types of interview are regularly employed: the focused structured interview, the semi-structured interview, the group interview and the unstructured interview. The most important distinction is between structured and unstructured. The unstructured interview is an important tool for the qualitative researcher, because with "its naturalistic observation there is no predetermined set of expectations on

the part of the researcher" (May 1993: 92. cited in Hall & Hall, 1996). That is, the researcher does not ask leading questions. The structured interview is "often more quantitative in nature and clear objectives will have been identified in advance of the first interviews" (McQueen & Knussen, 2002: 36).

The interview technique employed in this research was generally semi-structured but the interviewer was free to move into a less structured format. The interviews for Non-Consultant Grade were based on 12 guiding questions, while the Consultant Grade interviews included an additional three questions for those respondents who were appraisers. The interviews were tape-recorded by the interviewer following informed consent by the interviewee. The interviewer can seek both clarification and elaboration on the answers given in the questionnaire (May, 1993).

The purpose of using interview data in this study was, by the application of qualitative methods, to enhance the previous quantitative data from questionnaires survey and to explore the following research questions in depth:

- *How do doctors respond to the implementation of the performance appraisal process in the NHS?*
- *How do doctors express the problematic of the current appraisal process?*
- *How far do doctors believe that appraisal linked to revalidation will strengthen the control of the medical professional, to identify problem doctors and to improve patient safety?*
- *How far do doctors believe that it is possible to closely regulate doctors, given the nature of the work they perform?*

1.

Following the prior questionnaire survey, volunteers were sought for subsequent follow-up interviews. However, Eades, *et al.* (2006: 19) commented that "from the first cohort we make no claims here as to the representative nature of the observation." Of the 52 interviews, conducted by the research team, 44 were conducted face-to-face and eight by telephone. There were two sets of data examined from the interviews - Consultant and Non-Consultant Grades.

Each interview lasted between 45 minutes and one hour. The conversation was recorded by tape recorder to "obtain a full description of the participant's concerns and to enable the researcher to systematically probe the meaning of texts" (Sanders, 1982, cited in Som, 2009: 101). However, McQueen & Knussen (2002:36) point out "there are practical problems in recoding of narrative and there are difficulties inherent in the analysis of such rich and descriptive material." In some cases, due to technical circumstances, the audio quality was poor and this may have led to misinterpretation of some of the replies to the questions.

The interviews in this study were semi-structured, open-ended with a package of available pre-designed questions, assembled by the research team. May (1983: 93) contends that, though the interview questions are normally specified, the method allows the interviewer greater freedom "to probe beyond the answers in a manner which would often be seen prejudicial to the aim of standardisation and comparability." Researchers have to be aware that "the context of the interview is an important aspect of the process" in semi-structured questions (ibid.).

All respondents were asked similar questions in random order in the interview. There are advantages and disadvantages in such an approach, according to Hughes (cited in Greenfield, 1996:171) as "respondents answering the same questions will increase the comparability of responses. Data are complete for each person on the topics addressed in the interview. However, there is little flexibility in relating the interview to particular individuals' circumstances or particular context."

Nevertheless, there was no pre-set response categories prepared for the interviews, because they might limit the field of inquiry. The questions were open-ended in this interview design, because the research team believed that it would allow informants to discuss the issues more freely, compared with the closed or forced-choice questions of the structured questionnaire. Also the interviews had a flexibility, which the survey lacked (Hall & Hall, 1996). These techniques allowed the researchers to focus on the meanings and interpretations that individuals attribute to events and how their attributions related to the research questions in this study. Open-ended questions also provided "a greater understanding of the subject's point of view" (May, 1993: 29). Additionally, "it offers a rich source of descriptive information" (McQueen & Knussen, 2002: 36, cited Godin, *et al* 2006: 9).

The advantages of using interviews, suggested by Lang & Heiss (1994: 112) are "the flexibility to deviate from the set pattern of the questions if the need arises and the ability to probe areas of interest or vagueness instead of relying on routine responses." Also direct "communication between interviewer and the respondent" allows the researcher "immediate checking on information" (ibid.). They also indicated the disadvantages of using interviews, as it is time consuming and costly, and the greatest difficulty is "the problem of determining the worthwhileness of the information obtained and the truthfulness of the information, and the interviewer's bias and subjectivity" (ibid.). Such that "subjects may be influenced by what they perceive to be the underlying aims of the investigation, or

the interview respondents may be influenced by the characteristics of the interviewer; such as her age, race, gender or whatever" (Bryman,1988:112).

This is known as social desirability response bias. Vice versa, the interviewer might be influenced by interviewee preferences or personal bias. Additionally the researcher should be aware of confirmatory bias, defined by Nickerson (1998: 175) as "the seeking or interpreting of evidence in ways that are partial to existing beliefs, expectations, or a hypothesis in hand." The analysis of the interview data took account of these biases, particularly to avoid personal assumptions and personal judgments (confirmatory bias) and to evaluate the occurrences of social desirability biases from the interviewees.

4.5 Data analysis

5050 questionnaires were distributed to Non-Consultant Career Grade (NCCG) doctors in the NHS in England. 1432 questionnaires were returned completed. This represents a 28% response rate. The 28% return rate from NCCGs attracted the researcher's caution and suspicion. It might indicate a low level of the respondents' willingness to participate in the research as well as their lack of openness. Other possibilities may reflect the content of the questions designed. The NCCGs may have felt sceptical or disillusioned with the appraisal process and therefore did not wish to take part in the survey.

A total of 1143 questionnaires were also distributed to the Consultant Career Grades (CCG), for those who both acted as appraisees and appraisers in the Mersey Deanery, which covers hospital trusts in the Merseyside and Cheshire region. There were 417 questionnaires returned and this represents a 36.48% response rate, which was higher than from NCCG doctors. Yet, the extent to which questionnaire surveys are good measures relate to the degree of question reliability (Sheatsley, 1983; Fowler, 1993). Nevertheless, the data collected from the questionnaire survey had to be coded and input before the results could be described and analysed.

According to Yin (1994), it is necessary have a general analytic strategy to clarify what will be analysed and for what reason. The questionnaire data has been analysed in this research based on descriptive statistics to identify variables affecting both career grades' response rates and the acceptability of appraisal process. The relatively low response rates from both grades' surveys (NCCG, response rate 36.5% and CCG 28%) may suggest a possible defensive stance towards the implementation of appraisal within the NHS in general.

Frequency distributions were analysed by Chi-squared tests whenever necessary and appropriate (Frequency distribution: http://otel.uis.edu). The "purpose of a frequency distribution is to summarise and organise a set of data. Presenting data in a frequency distribution makes inspection of the data set much more manageable than presenting the entire set of raw data." (Gemmill, *et al*, 2006: 211). The rational of applying Chi-squared tests in this study according to Rao & Scott (1981: 221) is "because of its simplicity to screen out a large number of two-way (or higher-dimensional) tables at minimal cost to identify tables of interest." The frequency distribution tables and Chi-squared tests may be found in Appendix E.

Yet, the data subsequently used from the questionnaire surveys relied very largely on the open-ended questions (where respondents are freely expressing their concerns). Robson (2002) argues that some closed questions, where there is a choice among fixed alternatives, might make the respondents reluctant to make a choice. The data from open-ended questions included in the questionnaire (NCCG eight & CCG ten) have been subsequently coded for this study and the "analysis of the data proceeded by detailed scrutiny of the selected transcripts to identify key themes" (Featherstone & Donovan, 1998: 1178).

The data were examined for similarities and differences within each key theme, within which several categories were identified. In order to answer the research questions about the instrumentality of appraisal and its implementation, this researcher has coded both NCCG and CCG questionnaires, and categorised them into five major clusters:

- *How medical professionals viewed management attitudes to the implementation of appraisal in their Trust*
- *How respondents perceive appraisal in terms of its functionality*
- *Appraisal implementation problems identified by doctors*
- *The strengths and weaknesses of the appraisal processes*
- *Changes in the doctors' behaviours in response to appraisal*
-
-

These categories were first used to describe the information gathered and then developed for interpretations of the data. The data contribute to the assessment of the extent to which appraisal is being used as a control mechanism by the government and the processes which could prevent it becoming an effective control mechanism. These categories were expected to provide explanations of the data. The details of the findings from these are analysed in Chapter 5.

The interview data examined from the interview identified by the two grades of medical professionals Non-Consultant and Consultant Career Grades. The interviews were

transcribed, coded and subsequently analysed based on a descriptive approach. The analysis was preceded by detailed scrutiny of the transcripts, which were selected to identify key themes to enhance the questionnaire findings, from both sets of interview data. The interviews generated rich data on the practical concerns regarding the implementation of appraisals in the NHS Trust. The purpose of analysing the interviews was firstly to focus on issues from the questionnaires and secondly to provide additional depth to this study, in order to answer the research questions.

Interview data analysis in this study is based on three major themes emerging from both career grades, which the researcher has categorised as:

- *How doctors perceive appraisal in terms of its functionality*
- *How appraisal may be used as a change tool to affect the doctor's job satisfaction, motivation and commitment to healthcare.*
- *Changes in doctors' practice in response to appraisal*

Reflection on the key "emerging themes helped the researcher to interpret the different possible meanings and integrate them into structured descriptions" (Reisetter *et al.,* 2003; cited Godin, *et al.*, 2006: 9). Subsequently these structured descriptions resulted "in the identification of important themes" (ibid.) around the essence of interviewers' practical concerns over the implementation of appraisals. The interview questions for both grades will be found in Appendices A, B & C. The researcher is aware that qualitative data analysis can be assisted by the use of computer software to facilitate in storage, coding, retrieval, comparison, in order to linking the data to research questions (Patton, 2002). But because the research was facing the pressures of project deadlines and other time related pressures, constraint in "mastering the software in order to free the researcher to perform in-depth analyses and interpretation of the data" (Baugh, 2010: 72), the software was not used.

Therefore, the traditional, open-ended analysis approach has, to this point in time, been used by in this study. Theoretically, analysis of the qualitative data proceeded by detailed scrutiny of the selected transcripts to identify key themes in three stages, data are examined for similarities and differences within concepts, according to constant comparison methods based on grounded theory (Glaser & Strauss, 1967). There are categories used to describe the information gathered are developed from an interpretation of the data, by grounding the theory on the facts of data. The relationship between the assumption and these categories provide an explanation of the material. By using open coding as the first stage, the detailed notes taken from the questionnaires' open-ended questions as well as the interviews, as the researcher tried to identify passages of the text that related to a themes or concept, and grouped similar concepts into conceptual categories. The second stage involved carefully

sifting and examining the notes, labelling and categorising the particular phenomena to develop the conceptual categories and compare them with each other. And in the last stage formulated selective patterns of relationship between the observed elements were then found.

Technically, the qualitative data analysis in this study is based on the manual processes of qualitative research. The researcher remained flexible and open, in other words, the researcher adapted Yin's (1994) pattern-matching as the analytic techniques for categories, concepts and patterns to emerge from the data. Similar strategies in Miles & Huberman's (1984, 1994), coding and categorizing were inductively generated by researcher's observations, notes, and analytic memos, and were also guided by the theoretical framework. This feature resembles the "by hand" method, use of coloured highlighters for coding qualitative data for example. The methodological perspective in respect of qualitative data analysis in this study was grounded in inductive and interpretative data-based analysis. The inductive interpretative analysis process enabled the results to be framed as empirical assertions, and included the classification of the substance (Yin 1994). By using such a strategy to develop a descriptive framework around which the key themes are organised. This approach is responsive to researcher insights and to information that arose from the data, discussions with supervisor and peers, and reviews of pertinent literature.

4.5 Conclusion

This chapter has sought to discuss some self-reflections on the rationale, methodology and relevancy of this research. It has illustrated what I have learnt from this research journey. Some of the arguments and rationales for combining quantitative and qualitative methods of investigation are analysed. The combination adopted here tended to facilitate a full understanding and exploration of the nature of the inquiry of this study. The researcher has evaluated the qualitative and quantitative characteristics in the research process in general and the methodological concerns related to the methods in this study. Two different techniques have been discussed in detail and the purposes of applying multiple methods in this study also have been addressed.

The methods adopted allowed the exploration, on a macro-level, of the problematic of organisational control mechanisms in the NHS and the conflicts between doctors' self-regulation and organisational control. In this case the government intervention imposing appraisals was analysed by the employment of a qualitative method, supported by reviews

of policy documents. At the micro level, in researching the perceptions and concerns of individual doctors about how appraisal leading to revalidation could improve the control systems and improve health care, quantitative (questionnaire) and qualitative (interview) methods were used in tandem.

Chapter 5, based on the quantitative and qualitative empirical data and their analysis, will explore the possibility of the implementation of formal appraisals as one of the control mechanisms to monitor professionals' performance and what may prevent it becoming so.

Chapter 5

ANALYSIS OF QUESTIONNAIRES AND INTERVIEWS

5.1 Introduction

Chapter 5 will examine the empirical findings from two sets of questionnaire surveys and semi-structured interviews from Non-Consultant Career Grade (NCCG) and Consultant Career Grade (CCG) medical professionals within the NHS in England. The aim of the empirical work presented in this chapter is to explore the use of appraisal leading to revalidation (ALR) as a control mechanism within the NHS and analyse doctors' views and responses to the introduction of professional performance monitoring in healthcare. The structure for compulsory appraisal, although first mooted by Griffiths (DoH, 1983), was set out in *Supporting doctors, protecting patients* (DoH, 1999a) and from this point, "as a political concept, 'revalidation' had been launched" and to be implemented from April 2005 (Salter, 2007: 266).

Influenced by the fifth Shipman report (Smith, 2005), which addressed appraisal and revalidation, the Chief Medical Officer instigated a review of revalidation in the consultation paper *A call for ideas* (DoH, 2005) informed by the General Medical Council's revised doctors' code of practice (GMC, 1995). The purpose of this code was to strengthen procedures for professional self-regulation through revalidation and included the requirement to take responsibility for colleagues' performance. Whilst there was general approval for revalidation, "alongside this was a shared anxiety about the practicalities of its implementation, and an acknowledgement that public confidence will, paradoxically, be damaged unless the profession can move quickly to ensure that the implementation is effective" (Levenson *et al.*, 2008:63).

The analysis will be organised thematically around the various research questions, with the main focus on to what extent the government is able to control the medical performance of doctors through appraisal, probably linked to revalidation of the licence to practice. Also, evidence presented in this chapter intends to address following key research questions in this study:

- *What is the functionality of appraisal?*
- *Is appraisal being used as a control mechanism?*
- *Does appraisal appear to be implemented successfully?*

- *What could prevent appraisal becoming a control mechanism?*
- *How far do doctors believe that it is possible to control doctors, given the nature of*
- *their work?*

This chapter is structured as follows. Section 5.2 concerns the functionality of appraisal which is an underpinning research question that has already been partially addressed in the literature review (Section 2.5). The tensions between formative and summative functions are addressed, the allocation of resources to personal development explored and the degree of recognition of doctors' contributions to their Trusts assessed, though the summative function is dealt with more fully in Section 5.4. In Section 5.3 the doctors' views on the quality of the implementation of appraisal are analysed. Subjects covered are the awareness of the aims and objectives of appraisal, individual histories of appraisal, as well as the advice and information made available, the time allocated and the training given for preparation as appraisees and appraisers.

Section 5.4 analyses the survey and interview data around the research question related to the use of appraisal as an NHS control mechanism, building upon the literature review. It considers the NHS's use of appraisal in its summative mode as a means of detecting unacceptable clinical performance and the respondents' perspectives on the political nature of the process. It also analyses the doctors' opinions about the link to revalidation. Section 5.5 evaluates responses, some implicit, to the research question about the extent to which doctors believe that they can be externally controlled, given the nature of the work they do. Proxies were used to code the data around behaviour changes in clinical practices prompted by appraisal and organisational culture changes that would deliver improved patient safety.

Section 5.6 analyses the doctors' responses around the research question that asks what could prevent appraisal becoming a control mechanism. The three emergent themes are: the potential for resistance due to loss of professional autonomy; the likelihood of passive resistance to appraisal due to possible erosion of job satisfaction, commitment and motivation that the process generates; and the endemic organisational limitations that its operationalisation seems to have brought with it. Section 5.7 provides a conclusion which looks towards the findings and implications to be addressed in Chapter 6.

5.2 The functionality of appraisal

Appraisal may be seen to be of two types - summative and formative - as may be seen from Chapter 2. This section applies those concepts to the data. Formative appraisal was

considered by the Chief Medical Officer as helping doctors "consolidate and improve on good performance" (Colthart *et al.,* 2008: 82). Thus the formative basis of appraisal is generally educational or developmental in nature. Summative appraisal is more judgmental, deals in performance standards and is generally top-down. It is gathered for audit purposes to ensure an effective clinical governance system. "Information gathered under the 'knowledge and skills' framework for appraisal should be used as far as possible as the basis of revalidation" and this implies that the appraisal evaluation will be both summative and formative (DoH, 2007b: 34). Thus, "there is a natural, potentially creative tension between the two purposes of appraisal" (Taylor, *et al.*, 2002: 668).

A key theme from the questionnaires and interviews relates to the functionality of appraisal. This considers professional development needs, job plan and resources concerns and also the recognition of individual professional contribution of doctors by the Trust. Formative appraisal aims to "set out personal and professional development needs" and "agree plans for them to be met" according to the Department of Health (1999: 1), which fails to mention the allocation of resources to implement these plans, whilst mentioning resources for service needs.

It was found that most respondents and interviewees realised that appraisal is both developmental and judgmental: for revalidation assessment is its function, whereas for personal development it is supportive and encourages reflection on practice. Some interviewees expressed concerns about how these competing functions and different components are may not be easy to reconcile in practice. The benefits of one mode might be negated by the second mode.

Professional development needs, job plan and resources

The themes identified were: first, time devoted in the appraisal to professional development; second, the extent to which development needs had been met in the appraisal; and third, satisfaction with resources allocated to personal development as identified in the appraisal.

Table 5.1 shows that 83.8% of a total of 1007 Non-Consultant Career Grade (NCCG) respondents claimed that they had been given sufficient time for a full discussion about their professional training and development needs at appraisal. However, the overall response rate 59% out of total 1423 might suggest that a large part of NCCG respondents have not been given quality of time during appraisal compared with a response rate of 87% out of total 417 Consultant respondents. But some expressed an opinion that subsequently the Trust failed to actually address these professional needs. "Needs are discussed yes, but

they then do nothing" *(Staff Grade Paediatrics 0863).* Some appraisees had the impression that their professional needs in the appraisal process were merely discussed but the real focus was on service delivery and the identification of the organisation's service needs. Consultant Grades did express satisfaction with the time devoted to discussing personal development needs.

In Consultant interviews, the majority of interviewees believed that appraisal could help individual professional development. There were, however, interviewees who expressed negative views of the appraisal process. Many of them did not believe that appraisal was being used to improve professional development. As one put it, appraisal is "just a ritual, but I wonder whether I should take steps to make it a useful process or if I should shrug my shoulders and let whoever it is go through the rigmarole of it" *(Consultant 002).* Another Consultant questioned the cost/benefit of appraisal for development because "most people are professional enough to do their own stuff to keep up to data and it is a long process - the paperwork, and the appraisal is time consuming." It is "a sledgehammer to crack a nut" *(Consultant 003).*

Table 5.1a Adequacy of time devoted to personal development during the appraisal.
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Non-Consultants	1007	0.00	2.00	0.8500	0.37352
Consultants	405	0.00	2.00	0.9259	0.31378
Valid N (listwise)	405				

Table 5.1b Explanation of adequacy of time devoted to personal development during the appraisal

Non-Consultants				Consultants	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No	157	15.6	36	8.9
	Yes	844	83.8	363	89.6
	Partial	6	0.6	6	1.5
	Total	1007	100.0	405	100.0
	Not stated	406		2	
Total		1423		417	

Table 5.1 Adequacy of time devoted to personal development during the appraisal.

Table 5.2a Personal development strategies met in the appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Non-Consultants	873	0.00	3.00	0.9221	0.42392
Consultants	368	0.00	3.00	0.7663	0.51119
Valid N (listwise)	368				

Table 5.2b Explanation of personal development strategies met in the appraisal

Non-Consultants				Consultants	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No	103	11.8	98	26.6
	Yes	747	85.6	261	70.9
	To some extent	11	1.3	6	1.6
	Don't know	12	1.4	3	.8
	Total	873	100.0	368	100.0
	Not stated	550		49	
	Total	1423		417	

Table 5.2 Personal development strategies met in the appraisal

Table 5.2 shows that 85.6% of the respondents out of a total of 873 Non-Consultant Grade and 70.9% out of 368 Consultant Grades claimed that the professional training and development needs had been met in the appraisal. Nevertheless, the overall response rate of 61% out of total 1423 Non-Consultant Grade shows positive responses compared with 88% out of total 417 Consultants responses. Some Non-Consultant Grades also indicated that they had "no faith" in whether these needs will be implemented or not. NCCGs were, on average, less satisfied with the meeting of their personal development strategies in the appraisal than Consultant Grades. This lack of satisfaction needs further exploration.

Table 5.3a Satisfaction with the level of resources allocated to meeting development strategies
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Non-Consultants	669	0.00	1.00	0.7025	0.45748
Consultants	254	0.00	2.00	0.6299	0.51542
Valid N (listwise)	254				

Table 5.3b Explanation Satisfaction with the level of resources allocated to meeting development strategies

Non-Consultants				Consultants	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No	199	29.7	98	38.6
	Yes	470	70.3	152	59.8
	To some extent			4	1.6
	Total	669	100.0	254	100.0
	Not stated	754		163	
	Total	1423		417	

Table 5.3Satisfaction with the level of resources allocated to meeting development strategies

Table 5.3 shows that there is a lack of satisfaction from both Grades about the level of resources allocated by Trusts to meet the agreed personal development needs and strategies, with Consultants being less satisfied. The response rates to this question were low (33% out of total 1423 Non-Consultant Grade and 36% out of total 417 Consultants respondents). One respondent commented that the Trust needs to provide "enough resources, so that doctors can attend relevant courses" *(NCCG Doctor 0845).* Another argued that there is need for Trusts to "support non-consultant grades with the PDP [Professional Development Plan] process" *(Staff Grade Psychiatrist 0813).*

Supporting the questionnaire results, the semi-structured interviews revealed in-depth insights into the functionality of appraisal. There were many interviewees who considered that appraisal in itself was good and it had provided opportunities for professional development, though some of them admitted that they did not have much experience of it, even though appraisal has been good practice in commerce and industry for a long time. The interviewee evidence suggested that although Consultants agreed that appraisal is developmental for the individual professional, they tended to identify issues only relating to their technical performance rather than improving their 'soft skills.' This may suggest that they are not aware of how to address these issues. So whilst appraisal, in principle, has the potential to assist with personal development and in practice was stated to have done so in some cases. Overall the lack of initiative and resources from the Trusts diminishes its potential benefits.

One informant pointed out that appraisal was "a positive experience. I learned from it" *(NCCG Doctor 0315).* But another suggested that it was a bureaucratic system which appeared to obstruct full professional development in the Trust. This interviewee went on to say, "When I do want to develop I make a report of that. That goes through to the Medical Director, who then reports to the Chief Executive, so there is a record of where you might like to develop. Whether your Trust will support you in doing that providing you wish study

leave, providing you with finance are very questionable. And there is a threat out there that they will be less inclined to do that unless they see specific service benefits for the Trust" *(Associate Specialist Anaesthetist 001).* One has complained that, "objectives and professional development aims are never met because there is no resource to do so" *(Staff Grade 0914).*

Similar to the findings from the questionnaires, the analysis of the interviews revealed that many interviewees believed that Trusts have failed to properly implement individual development plans. In some cases, even though the professional development needs were identified via the appraisal process, there was "no support from the Trust to develop these areas further and move forwards. From the appraiser's point of view, appraisal was just about conducting the appraisal - a tick in the box. Afterwards the onus is on the appraisee to take any action" *(Associate Specialist Paediatric Cardiology 108).* And one interviewee claimed that the appraisal process "probably doesn't add much in terms of additional reflection. It might help to formalise the development plan and add weight to it" *(Associate Specialist 0156).*

Whilst questionnaire respondents agreed that sufficient time had been devoted to development needs in the appraisal interviews (84% and 87%), there was more dissatisfaction with how those needs were addressed from Non-Consultants than from Consultants. However, the greatest criticism from both groups was the lack of resources to meet these identified needs. So resourcing issues mean that even if training needs are identified through appraisal, there is insufficient help in developing further to meet them. "It's all still driven by the individual. There is no particular allocated time; we just fit things in between our clinical commitments" *(Associate Specialist 206).* However, there were suggestions that appraisal is not necessary to enable professional development to take place, suggesting other means could be employed. An issue to be addressed in Chapter 6.

Professional contribution recognition by the Trust and resources concerns

Another functional aspect of the appraisal could be the examination of the extent to which Trusts recognise the respondents' individual contributions to their Trust. One respondent pointed out that, "whereas I feel my work is recognised within the department, especially by nursing staff, I feel the Trust is unaware of my existence other than as a small statistic" *(Staff Grade 1413).* And one had claimed that for the Trust "I'm considered as a 'work horse' of no importance!!!!" *(Associate Specialist 1043).*

Another respondent stated that appraisal does not help managers to recognise individual contributions, because "managers have little or no idea of the jobs of doctors working in

their Trust. The Trust service plan is created by managers outside of the appraisal" *(Consultant Pathologist 197).* Table 5.4 shows that two thirds of both Grades were satisfied with the recognition of their personal contributions to the Trusts.

Table 5.4a Opinion on recognition of individual contributions to the Trust
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Non-Consultants	984	0.00	3.00	0.7713	0.60142
Consultants	402	0.00	3.00	0.6716	0.54397
Valid N (listwise)	402				

Table 5.4b Explanation opinion on recognition of individual contributions to the Trust

Non-Consultants				Consultants	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No	288	29.3	143	35.6
	Yes	661	67.2	252	62.7
	To some extent	7	.7	3	.7
	Not sure	28	2.8	4	1.0
	Total	984	100.0	402	100.0
	Not stated	422		15	35.6
	Total	1423		417	

Table 5.4 Opinion on recognition of individual contributions to the Trust

However, there were 28.7% of Non-Consultant Grades who believed that their contributions had not been recognised by the Trust. One respondent clearly stated that "as a staff grade, I am used to little recognition from senior colleagues and the system" and further added, "I am used to more than full capacity, but have no future. We often have to fill in and do the work for consultants but [with] no financial or any other benefit from it" *(Staff Grade 1389).* And that "middle grades are the invisible work force in the Trust and their work undervalued" *(Staff Grade 0642).* Many respondents expressed frustration and anger at the lack of recognition by the Trust of their personal contributions.

The respondents also claimed that Trust managements lacked involvement and interest in the Non-Consultant Grades. For example, one respondent spoke out about disappointment with the appraisal process and felt that the appraisal did not help the Trust management to recognise individual contributions because "after months of effort to prepare the appraisal, to find that only my named consultant will see it, and the clinical and medical directors and Chief Executive will not be involved at all" *(Associate Specialist - Dermatology 0980).* Another interviewee described the appraisal experience as "only a very brief 15 minutes paper exercise, not a discussion, not looked at my presented evidence or a two-way process" and further expressed disappointment with the appraisal "if mine is an accurate

reflection, then this is not the way to conduct appraisal [to make them] meaningful" *(Associate Specialist 2150).*

Table 5.4 also shows that 34.6% of Consultant Grades believed that their contributions had not been recognised by the Trust via the appraisal process. Some respondents expressed the opinion that the NHS is not particularly interested in individual development, "the organisation's drive is to meet Government service targets" *(Consultant Orthopaedic Surgeon 236).* And one described the appraisal process as being "incapable of recognising 'value' and 'contribution' in its present form" *(Consultant 014).* Another Consultant claimed that the current appraisal system was "directed to finding faults, real or imagined, and no account is taken of long-term good service by clinicians to patients, with no serious complaints" *(Consultant 215).*

In addressing the functionality of appraisal, building on the concepts already identified from the literature in Section 2.5, the formative function of appraisal was recognised as being important to doctors. Both Grades held positive views that their professional needs had been identified via the appraisal process. However, there was considerable evidence that Trusts have failed to implement personal development plans after appraisal, with inadequacy of resources being offered as the principal reason.

However, Trusts seemingly mostly failed to resource development needs and failed mostly to recognise professionals' contribution via the appraisal process. Both Grades believed that their professional contributions had not always been recognised in the appraisal process, and there was considerable evidence from lower grades that their professional contributions have been neglected by some of the Trusts. Common criticisms were: no recognisable outcomes from appraisal; personal contributions ignored by Trusts; and limited recognition.

Appraisal, if implemented efficiently, is considered to have several functions including enhancing individual professional development, revealing poor clinical performance and contributing to a process of revalidation. Evidence from the interviews suggests that some of these competing functions may not be easy to reconcile. The summative functions of appraisal are considered more fully in Section 5.4, which is concerned with the use of appraisal as a control mechanism.

5.3 Implementation of appraisal

In addressing an underpinning research question around the success or otherwise of the implementation of appraisal, this section presents the data from questionnaires and interviews in which doctors, both as appraisers and appraisees, have expressed their views on implementation. This section will first review the data on the awareness of Consultant and Non-Consultant grades of the introduction of appraisal, whether they had been appraised in the last year, and if they were aware of the aims and objectives of appraisal. Secondly, it will review the relevant data around the availability of training resources to support appraisal, the time allocated for professional preparation, and information and advice provided for appraisal.

Awareness and personal history of appraisal

The evidence shows that 85.6% of Non-Consultants were aware that their Trust had introduced appraisal, with a 61.3% response rate out of a total of 1423 (Table 5.5 Appendix E). For Consultants 99.3% out of a total of 417 Consultants claimed that appraisal has been introduced for them in their Trust (Table 5.6 Appendix E). However, there was evidence to indicate that some Trusts at the time of the survey had not fully implemented appraisal, or lacked the initiative to conduct appraisals in keeping with Department of Health guidelines. One respondent stated that "they [the Trust] do not read or discuss with us what is our need or what shall we do/or they will do, to achieve it - that only happened through individual negotiation - not as a result of appraisal" *(Staff Grade 0875).* Another claimed that in his/her Trust there was "no encouragement to conduct appraisal from management - we are doing it all ourselves" *(Associate Specialist 0337).*

This patchy implementation of appraisal may be indicated by the fact that 66.4% out of total 1422 Non-Consultants had been appraised in the last 12 months and that there were 33.6% of staff who had never been appraised at the time of the survey (Table 5.7 Appendix E). However, 91.8 % out of total of 417 Consultant Grades had been appraised within the last 12 months (Table 5.8 Appendix E). The disparity between Consultant and Non-Consultant is now explored, since it seems as though the Non-Consultant Career Grades are "a forgotten tribe" (Claxton & Griffin, 2006: 369).

The data show that some Non-Consultants have not been appraisal for the last two years *(Staff Grade Clinical Oncology 1078).* Another respondent claimed that the last appraisal "was in September 2002" *(Staff Grade 2664).* Others reported not having been appraised because of the absence of leadership, which might negatively affect the appraisal process. As one respondent pointed out, "I have not had an appraisal for four years; we are waiting

for the appointment of a new clinical director. Our old one died, and other senior staff just 'keep the ship afloat,' but we need a new director ASAP" *(Senior Dental Officer 1001).*

Such evidence appears to question whether Trusts intend to focus on the appraisal of certain groups of respondents. In commenting on the different level of actual appraisals between Consultants and Non-Consultants, one respondent pointed out that "the Trust does not appear to be actively pursuing appraisal amongst NCCG doctors" *(Associate Specialist 0782).* It would appear that Non-Consultant Grades are given less opportunity for appraisal than Consultant Grades and this may lead to inequitable chances for professional development. However, from such limited data, it is impossible to be definitive and so this issue has to be examined more fully and combined with other aspects of evidence to reach a comprehensive conclusion.

Evidence suggests that some Trusts had failed to conduct appraisals because of inefficient management as there were "no clear arrangements on who will do appraisal and no one has an interest in the needs of NCCGs [Non-Consultant Career Grades]" *(Staff Grade 0914).* Data from the survey also show that some Trusts seemed to lack the initiative to organise appraisals. One respondent stated, "I have to chase and beg to be appraised annually" *(Senior Clinical Medical Officer 0724).* One respondent described their Trust as having a "laid back approach" towards appraisal *(Associate Specialist 1005).* Yet another respondent claimed that in their Trust "there is no policy for appraisals in place, only the SAS doctors who request to be appraised actually receive appraisal" *(Associate Specialist 0331).* These might give an indication to the Trusts whether they could improve the appraisal process or not in a practice setting. There was suspicion from one respondent, viewing it as "difficult" to achieve, only the benefits "perhaps mostly by improving trust and goodwill between consultants and non-consultant staff within the department" *(Associate Specialist 0869).*

The third area of concern was the knowledge about the aims of appraisal. Out of 1391 Non-Consultant responses, 94% were aware of the objectives of appraisal leading to revalidation (Table 5.9 Appendix E). However, more Consultant than Non-Consultant Grades were aware of the objectives of the appraisal - 98.5% out of a total of 413 respondents (Table 5.10 Appendix E). However, one Consultant pointed out that in their experience of "NCCG doctors, fewer understood the limits of appraisal" *(Consultant 189).* Another Consultant stated that people were "confused about the appraisal relationship with assessment and revalidation" *(Consultant 240).* A Non-Consultant claimed that there was "poor communication of the process of appraisal and lack of information from the Trust in

preparation for it. I got the information and forms from the DoH website through my own initiative and had to request an appraisal" *(Staff Grade 0946).*

One respondent claimed that the Trust showed little interest in professional needs during the appraisal, that the only topic of concern, repeated every year, was about overspending and that nothing happened after being appraised. The Trust should seek the "establishment of a structured appraisal programme with coordinator, regulation body to review/audit appraisal process yearly" *(NCCG Doctor 0841).* And the appraisal process should demolish "naming and shaming" *(Staff grade 0865).* It was further suggested that "A critical analysis should be done by the Trust and whatever deficiencies which come up should be highlighted and identified for the coming year" *(Staff Grade Accident and Emergency Medicine 0881).*

Some were concerned that after appraisal within some Trusts the implementation of change processes does not happen. As one respondent pointed out "the exercise [appraisal] happens but no changes will result" *(Staff Grade 0783).* Further, "The appraisal process has not had any significant impact on the problems facing the Trust" *(Staff Anaesthetist 0984).* It does not "affect professional behaviour; best outcome for a project holder is neutral" *(Staff Grade 1168).* These comments might indicate poor implementation of change within a Trust.

It was suggested that there should be "more alternative appraisers. This should not be a personal opinion but should be a neutral objective opinion about medical standards. Probably better if not appraised by line manager as he/she will be more interested in performance review" *(Associate Specialist 0879).* Some respondents suggested that the documentation for appraisal should be more efficient. It "should be brief," "shorter," "clearer" and have more "consistency" and if "it keeps changing, I doubt it will improve. It will only keep confusing us more and costing us more wasted time trying to figure the changes out" *(Staff Grade 0832).*

In comparing responses from both Grades, apparently Consultant Grades gave a higher questionnaire return rate, were more aware of the introduction of appraisal, more had been appraised, and more knew of the aims of appraisal than Non-Consultant Grades (Fig. 5.1).

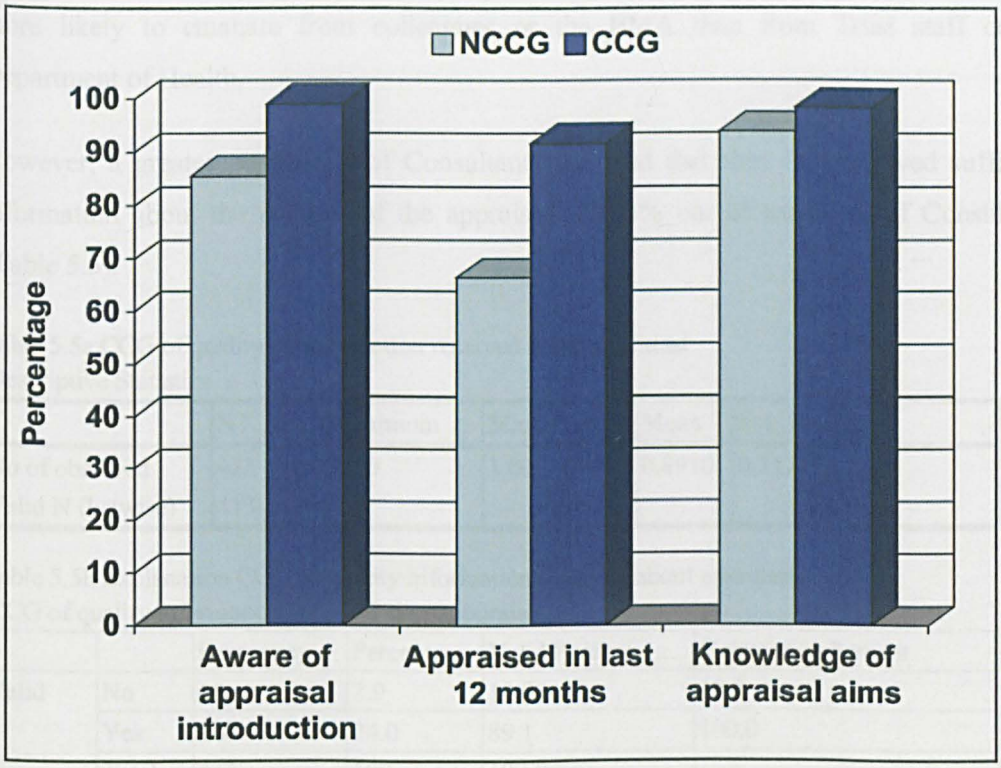

Fig. 5.1 NCCG and CCG responses compared

Resources allocated to appraisal

The second major theme was around the support for the appraisal process given by Trusts. The support was grouped under the headings of the quality of the information and advice provided, the time allocated for professional preparation, and the availability of training resources to support appraisers and appraisees.

Firstly, out of 1394 Non-Consultants 68% claimed that the information they had received regarding the purpose of appraisals was sufficient. However, 30.6% of them pointed out that they lacked information regarding the process of appraisal (Table 5.11 Appendix E). One doctor stated that "no information [was] coming out [from the Trust]. It seems to be it is voluntary for the individual to get an appraisal" *(Associate Specialist 0809).* This suggests that priority has not necessarily been given to supporting the process.

The second issue was concerned with the level and quality of information provided about appraisal. One respondent implied confusion and stress in the process as "they put you in a maze that has no end" *(Staff Grade Cardiologist 1421).* There is "no one available for guidance within the Trust" *(Associate Specialist 1357).* Another argued that "the Trust should conduct its own educational session for its staff on appraisal" *(Associate Specialist 0781).* The evidence suggests that the channels of advice for the Non-Consultant Grades are

more likely to emanate from colleagues or the BMA than from Trust staff or the Department of Health.

However, a greater percentage of Consultants believed that they had received sufficient information about the process of the appraisal - 89.3% out of total 413 of Consultants (Table 5.5).

Table 5.5a CCG of quality of information received about appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	413	0.00	1.00	0.8910	0.31197
Valid N (listwise)	413				

Table 5.5b Explanation CCG of quality information received about appraisal
CCG of quality information received about appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	45	2.9	10.9	10.9
	Yes	368	24.0	89.1	100.0
	Total	413	100	100.0	
Missing		4			
Total		417			

Table 5.5 CCG of quality of information received about appraisal

Consultant Grades appeared to favour their colleagues and the BMA as their sources of advice, using the same channels as Non-Consultant Grades. Whilst both Grades recognised the objectives of appraisal (98.5% against 94%), the quality of information obtained about appraisal seemed to be in the Consultant Grades' favour (89.3% as against 68.9%). Equal access to information may be an issue, which might affect the full implementation of appraisal in the Trusts and indicate that priority is being given to Consultant Grades, leading perhaps to inequity.

The third issue was around the time allowed for preparation for appraisal. 79.7% out of a total of 1064 Non-Consultant Grades claimed that they had been given enough time to prepare for appraisal. But the overall response rate was only 59.6% (Table 5.6). However, fewer Consultants (76%) felt that they had sufficient preparation time allocated (Table 5.7).

Table 5.6a NCCG time allowed for preparation for appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	1064	0.00	1.00	0.7970	0.40243
Valid N (listwise)	1064				

Table 5.6b Explanation NCCG time allowed for preparation for appraisal
NCCG time allowed for preparation for appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	216	14.1	20.3	20.3
	Yes	848	55.4	79.7	100.0
	Total	1064	69.5	100.0	
	Not stated	359			
Total		1423			

Table 5.6 NCCG time allowed for preparation for appraisal

Table 5.7a CCG time allowed for preparation for appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	405	0.00	1.00	0.7605	0.42731
Valid N (listwise)	405				

Table 5.7b. Explanation CCG time allowed for preparation for appraisal
CCG time allowed for preparation for appraisal

	Frequency	Percent	Valid Percent	Cumulative Percent
No	97	24.0	24.0	24.0
Yes	308	76.0	76.0	100.0
Total	405	100.0	100.0	

Table 5.7 CCG time allowed for preparation for appraisal

The fourth issue was the amount and quality of the training for those being appraised and those conducting appraisal. This was not generally considered adequate, with 53% of Non-Consultant Grades, as appraisees, have been offered appraisal training but only 47.6% actually received the training (Table 5. 15 Appendix E). In comparison more training was offered to and delivered for Consultant Grades (63.6%) compared to Non-Consultant Grades (Table 5.16 Appendix E). Again, this evidence adds support to the tentative conclusion about the lack of equality of opportunity between the two Grades.

The views of the two Grades on the quality of the appraisal training varied, with Consultants being more critical - 32.2% as against 23.6% (Table 5.17 Appendix E). However, in respect of training as an appraiser, which is limited to Consultant grades, 79.9% received training but the response rate to this question was only 32.5% which seems very low in comparison to other questions. Of those who actually did receive training 82.7% were satisfied with its quality (Table 5.8).

Table 5.8a CCG training as appraisers received and comments on its quality.
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Training Received	134	0.00	1.00	0.7985	0.40262
Training Quality	104	0.00	2.00	0.8654	0.39555
Valid N (listwise)	104				

Table 5.8b Explanation of CCG appraiser training received and comments on its quality.

As appraisers received training				Training quality	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No	27	20.1	16	15.4
	Yes	107	79.9	86	82.7
	Partial		100.0	2	1.9
	Total	134		104	100.0
Missing	System	278		308	
Total		412	100.0	421	100.0

Table 5.8 CCG training as appraisers received and comments on its quality.

Table 5.8 shows that the response rates to both questions on training as appraisers and its quality, from Consultant Grades, is rather low. This might suggest inadequate skill levels and lack of support from Trusts for those responsible for appraisals of staff. "We need more SAS and consultant appraisers who have been trained in the appraisal process" *(Staff Grade 0837).*

The lack of satisfaction with the training by both Grades was attributed by them to:

- *The content was too basic*
- *Weak objectives*
- *Poorly organised and/or poorly delivered*
- *Arranged at short notice*
- *Insufficient scope of training*

One doctor suggested that the problem of ineffective training arose because the Trust does not have "enough information and talk just generally about it" *(Associate Specialist 0880),* and the content is just an "overview" failing to address specific concerns. It was geared more "towards consultants only, not applicable to other grades" *(Staff Specialist 2837).* The respondents have commented that the training lacked objectives and the content was confused. One claimed it "was in broad terms, contradicting, and containing ambiguous questions" *(Staff Grade Psychiatrist 0900).* Other respondents pointed out that some appraisers had not been trained for appraisal and this might affect the quality of the appraisal process.

In summary, the preliminary findings around implementation indicate that respondents from both Grades have similar views regarding its implementation. In particular, 28% of the interviewees reported that they had not been appraised within the last 12 months and in some cases they have not been appraised for several years. Furthermore, the Non-Consultant responses showed that some Trusts had focussed on Consultant rather than Non-Consultant Grades. A higher proportion of Consultants had received appraisal than Non-Consultants. These findings might suggest that appraisal has not been fully or uniformly implemented within the NHS. Both Grades claimed that they were aware of the objectives of appraisal, but less so on its link to revalidation.

Satisfaction with the quality of information received was higher amongst Consultant than Non-Consultant Grades. However, there was considerable evidence that there was a lack of knowledge, advice and clear information about appraisal from Trusts, especially for lower grade staff. Both Grades reported that they were given sufficient time to prepare for the appraisal. Non-Consultant respondents expressed significant concerns about the availability and quality of training, being poorly designed and poorly organised by Trusts. Several Non-Consultants responded that some of appraisers lacked training or were incompetent. However, the Consultant Grades held different opinions about the quality of appraisal, with evidence showing that more of them had been offered appraisal training than Non-Consultants and they were satisfied with its quality of their training.

Therefore, these different findings from both Grades indicate that there were problems about the quality of appraisal, which may be attributed to low levels of satisfaction with information and training provided, suggesting lack of HR support. Mohrman & Lawler (1999: 435) suggest that organisational change "will be successful only if the human resources of the organisation is supportive of the changes." In this study, the management level failure to implement appraisal effectively might lead to the conclusion that the professionals "did not feel positive about the changes in the organisation" (Mackenzie, 1995:75).

5.4 Appraisal used as an NHS control mechanism

This section seeks to address the research question about whether appraisal is being used by the NHS as a control mechanism, as suggested by the literature in Chapters 2 and 3. Evidence on this issue has emerged both from the questionnaires and the interviews. The two main themes to emerge from the data are the recognition of poor performance, especially of rogue doctors, and the linking of appraisal to revalidation and the licence to

practice. The evidence would suggest an emphasis on the summative nature of appraisal as "a process to identify underperformance" (Pringle, 2003: 438). This seems more judgmental, deals in performance standards and is generally a top-down approach.

Recognition of poor performance

The first issue of appraisal's utility in identifying poor performance was called into question in both questionnaires and interviews, in particular from several interviewees, often in strong terms. The survey results do not provide clear evidence to show that the appraisal process could be functional as a means of identifying poor performance. However, evidence from both Grade interviews showed that although many interviewees viewed appraisal as a good thing for monitoring professional performance, there were strong suspicions that political forces were driving appraisal.

The medical adverse events identified in Section 2.4, which were exposed for example in the *Shipman Inquiry* (Smith, 2004, 2005) and the *Bristol Inquiry* (Kennedy, 2001), put the government under pressure to increase scrutiny from the outside, because individual doctors had abused traditional self-regulation by the medical profession. However, from an interviewee point of view many felt that external regulation was being imposed on them because of isolated cases and that "appraisal would not necessarily detect incompetent doctors, but it could demoralise good ones" (Middlemass, *et al*; 2003: 780). "One GP like Shipman killed some of his patients, so then all the GPs are subject to control by the government" *(Associate Specialist 004).*

Several interviewees questioned whether the NHS would benefit from using appraisal to detect poor performance. One interviewee voiced concerns over this function of appraisal, "I have serious doubts. I think appraisal plays a limited role. Good practitioners will continue to practice well, and it would not make much difference to those who don't" *(Associate Specialist 008).* One criticism offered was that "the whole process still relies on individual's honesty. Appraisal itself would not pick up poor performance, like Shipman" *(Rheumatology 007).* Another said, "We're not very sure appraisal would do anything to catch the rogues" such as Harold Shipman *(Anaesthetics 009).*

One interviewee considered that doctors were victims of such external scrutiny from the government, and said, "to my mind, Mr. Wisheart and Mr. Dhasmana [Both cardiac surgeons who had been struck off by the General Medical Council - *Bristol Inquiry*, 2001] didn't get up one morning and say I am going to go out and kill four babies with heart defects today. That is not what you do as a doctor, and they were scapegoats for a huge breakdown [in the system] over a long period of time and they paid the price. And now

everybody else is paying the price, and I think that the price that has been paid is much in the interests of the Department of Health, and the control they want to exercise to bring everyone into line" *(Associate Specialist 001).* Another suggested that it was "a way of opening to scrutiny and audit" for the benefits of the organisation *(Staff Grade 2370).*

One respondent viewed his/her appraisal as "overall, seems like duty, not really an assessment of what I have done or want to achieve" *(Staff Grade 1305).* Further consideration is needed over how appraisal could be functional for monitoring poor performance under the current organisation with its present cultural forms and professional control methods. One respondent pointed out that "appraisal has no 'teeth' in its current organisation. I would prefer an assessment from the Department, more in-house discussion'" *(Associate Specialist 1004).*

There were concerns that the current appraisal process is not used for improvement of professional performance in some Trusts. Instead it was "used as an opportunity for criticism" *(Staff Grade 0965).* Evidence also showed that the way the appraisal was conducted made the professional "feel strongly that it is verging on being a paper exercise - more regulatory than about enhancing my performance etc." He/she further claimed that "the whole exercise has the potential to become meaningless, except to prevent future 'Shipman' cases" *(Associate Specialist 0877).* It is suggested that the appraisal process needs re-adjustment to enhance its function as a change agent to improve NHS performance. One respondent has expressed doubts, "I feel, like audit, it will soon start losing focus and direction - everybody forced to do it for record purpose, but with no effects or improvement" *(Staff Grade Paediatrician 1048).*

The Consultant Grades appeared to show similar concerns to Non-Consultant Grades in that they felt appraisal would not be the most efficient approach for the detection of poor performance in the NHS. One interviewee considered reliance placed on appraisal to unearth problems in practical settings and said, "I think the poor performer would on the whole be known in-house before it's picked up on any kind of appraisal thing. The question is how you get an honest opinion from people.....I think a lot of things went on behind closed doors, such as there was certainly the sensation of someone not doing that sort of procedure until we'd looked at the figures" *(Consultant Anaesthetist 004).* One interviewee voiced concerns that the process itself might not pick up potential problems within most NHS organisations and therefore "to appraise them is a waste of time" *(Consultant 003).*

Despite the general view of many interviewees that appraisal might not be effective in identifying poor performance; it might nevertheless be an approach for people to openly discuss unwanted behaviours. One emphasised that "I think that [there are] other ways to identify poor performance, and once poor performance or bad behaviour is identified then that is perhaps a good opportunity to discuss shortcomings" (*Eye Cancer Consultant 022*). Indeed, one Consultant commented that the current appraisal processes might not in fact detect problem doctors at all because "an incompetent, psychopathic or criminal doctor could easily perform a 'good' appraisal" *(Consultant 184).*

The functionality of appraisal to identify poor performance was not highly rated by many interviewees, who considered its utility to have been overestimated. For example, one interviewee commented that there "is a huge amount of work for everyone; it is detracting from patient care. If there really was a problem with my work, it probably could easily be disguised during appraisal" *(Senior Clinical Medical Officer 0162)*. There is a suspicion that appraisal was a 'knee-jerk' reaction by the government to the publication of the inquiry reports into medical malpractices during the first decade of the 21st Century. Whilst appraisal was first mooted by Griffiths in 1983, it was not until recent times that appraisal was introduced as a mandatory requirement for doctors. The circumstantial evidence around the timing of its introduction perhaps led one interviewee to state, "the process is a meaningless paper exercise to allow the government to claim that it is 'doing something' to prevent another Shipman/Ledward etc." *(Consultant 14).*

Whilst doctors recognised that appraisal was being used as a control mechanism by the NHS, the issue of poor performance is too multi-faceted to be addressed by such a simplistic device as appraisal alone. However, used as part of an overall process of revalidation it may have some contribution, though from the limited evidence presented here its effectiveness may be called into question.

Link to revalidation

The linking of appraisal to revalidation was explored in Section 2.5. The Green Paper *Supporting Doctors, Protecting Patients* stated that, "appraisal will form an important component of the systems required by the GMC for revalidation" (DoH, 1999; Para: 5.14, 5.15). Indeed, "Revalidation was conceived to detect unacceptable clinical performance" (Pringle, 2003: 437). This shift in government policy in granting licences to practice was extended to the development and surveillance of standards for medical practice. This is now seen as the key initiative for changing the NHS (DoH, 2007b). Whilst both respondent Grades expressed some positive views about appraisal in general, there was more caution

about revalidation and its link to appraisal. Here the link to revalidation is discussed in respect of its effectiveness, its practicality, its validity and its fairness.

As to effectiveness, evidence from the questionnaire and interview data suggests that there are concerns about linking appraisal to revalidation. In the Non-Consultant Career Grade questionnaires, there were no significant concerns about appraisals being linked to revalidation. However, in the Consultant Career Grade questionnaire survey, there were some issues raised. Some Consultants did not think that appraisals would effectively support the revalidation process (31.2%). For example, one stated that appraisal "depends ultimately on the honesty of the appraisee except in gross misconduct and aberration" *(Consultant Anaesthetics 040).* Many respondents had doubts that appraisals will link to revalidation. One Consultant pointed out that it was important to distinguish between appraisal and revalidation, stating that "appraisal is identifying needs of the appraisee, and revalidation is allowing the practitioner to continue practicing. These two have fundamentally different objectives" *(Consultant 039).*

There were further concerns that "revalidation is intended to identify doctors who are in some way under-performing or for some reason are a potential risk to the public. The appraisal process is incapable of doing this in its present form" *(Consultant 014).* Another doctor expressed a similar view, "I think personally within any population you will have lunatics, and it doesn't matter whether they are priests or members of parliament or doctors, you are going to have odd balls. I don't think you are going to weed them out. I don't think appraisal does. Most odd balls are quite clever at hiding their oddness, and again, the revalidation is the odd scenario. Extreme cases make bad precedence and revalidation came from the Bristol cardiac business" *(Associate Specialist 001).*

In respect of the practicality of linking appraisal to revalidation, there were concerns about the difficulty of working effectively on different aspects of appraisal, for example, its various links to clinical governance, complaints, development and revalidation. Although there is a link to revalidation from appraisal documentation, there were concerns about "how the revalidation process would work in practice" in many of the interviews (Smith, 2005: Chap; 26: 22). One expressed concern was the lack of clear differentiation between Consultants and Non-Consultants in the documentation. One Non-Consultant Grade argued that "the documentation we use comes from the consultant's documentation and it is not entirely valid for doctors. It would benefit from work on that and coming up with some better paper work. It takes you back to what appraisal is for" *(Associate Specialist 001).*

In respect of validity, several concerns were expressed around evidence and rigour. One respondent questioned the value of revalidation and suggested that there is an overlap of the control within the NHS. "The revalidation process is a farce – a lot of evidence won't be collected. There were systems already in place to identify doctors with problems. Relationships with colleagues, patients etc are impossible to objectively assess other than through complaints" *(Consultant 124).* Another suggested that the appraisal process "doesn't seem objective and comprehensive enough to pick out particularly bad performance if their colleagues are not aware about it" *(Consultant 178).*

One respondent claimed that there were inadequacies in the current appraisal process as it has "no evidence base: difficult if investigated to prove in practice." Therefore, it is unlikely to achieve support for revalidation *(Consultant 030).* From Consultant interviews, it was evident that some of the interviewees only understood about the links between appraisal and revalidation in a very basic way. One interviewee revealed "I don't think I've got my head around the link and what needs to be done now. I am not sure how much things have changed, if they really have changed, or if appraisal process does link to revalidation" *(A&E Doctor).*

In respect of fairness, several respondents expressed their doubts. One consultant pointed out that "there will be too much variation in the rigorousness of the appraiser for this to be a fair support to revalidation" *(Consultant Forensic Psychiatrist 417).* Others believed that its fairness may be compromised by the supposedly political motivations around its introduction. Some interviewees suggested that the current appraisal process seems pervaded by politics and too greatly influenced by the government's agendas. One respondent argued that "the appraisal and revalidation process is political cosmetics" and will not bring any change within the NHS *(Consultant 104).* One respondent suggested that the current appraisal process is "probably an unnecessary reduplication for political and bureaucratic reasons" *(Professor of Pathology 284).*

Although interviewees were aware of the nature of appraisal practice in industry as a kind of normative process, in the medical setting appraisal performance is linked to revalidation and therefore the licence to practice. Its inevitability was identified by one interviewee who stated, "I suppose that most professionals feel it's a bit threatening to some extent. But most of the department fear naturally. I mean that in some way they might feel irritation and frustration about the appraisal, and revalidation that becomes you know since we know we all are having to go through this" *(Associate Specialist 004).* Whilst revalidation was not

explicitly rejected, its linkage to appraisal was felt to make the appraisal process too much of an audit and so considered threatening to professional self-regulation.

In conclusion, considerable doubts have been expressed about the linking of appraisal to revalidation and from the survey it is difficult to adduce any direct evidence to suggest that the current appraisal linked to revalidation is actually a means of controlling doctors' performance by the NHS. Deficiencies in the clarity, the organisation, the uniformity and the fairness of appraisal might produce ineffective outcomes. It was felt that the process is not sufficiently rigorous, practicable, valid or equitable to be able to promote cultural changes in the NHS. However, one interviewee expressed positive views about revalidation being linked to clinical organisation, because "the question especially asks 'Are you up to date?'" *(Consultant 003).* But, "As a self-reflective process it is valuable. As a means to protect public from lunatic doctors, I don't think it is" *(Associate Specialist 001).* Most interviewees recognised that appraisal should be linked to other external processes, such as revalidation, and to internal processes such as the Clinical Governance framework. However as a potential control mechanism in the NHS, appraisal with its linkage to revalidation was recognised as such by many survey respondents and interviewees. But its effectiveness, validity, practicality and fairness were questionable.

5.5 The feasibility of controlling doctors given the nature of their work

One key research question is:

> *How far do doctors believe that it is possible to control doctors, given the nature of their work?*

The questionnaires and the interviews did not directly address this question. Nevertheless there was considerable comment around this subject. One Consultant typified such comment, talking about the appraiser:

> *"He does the front of the eye. I do cancer of the eyes - a totally different organ. He just provides a local service, whereas I am providing a national and international service. So he doesn't have an understanding of the nature of my work."*

Given the work which doctors do, several interviewees indicated the difficulty of collecting valid data, for example it was "extremely difficult to obtain objective evidence of anaesthetics" *(Consultant Anaesthetist 040).* Another claimed that the evidence presented was invalid because "the information provided related to statistical information about activity and FCE's [Finished Consultant Episodes] which was most inaccurate - therefore

valueless" *(Consultant 014).* One respondent claimed, "often the Trust did not have enough data on clinical activity. In one case, there were serious issues that could not be adequately explored because of this limitation" *(Professor & Consultant 290).* Another claimed that there were "no real data on performance for NCCG" *(Consultant 318).* Similarly the special doctor-patient relationship was difficult to evaluate since "There is no way of getting evidence about things such as doctor and patient relationship" *(Senior Medical Officer 0693).*

There were sufficient comments, directly and obliquely in the sub-text, addressing the issue of the difficulty of controlling doctors given the nature of medical practice to justify the creation of proxies for this major issue. One example is, "Managers have little or no idea of the jobs of doctors working in their Trust. The Trust service plan is created by managers outside of the appraisal" *(Consultant Pathologist 197).* These proxies are changes in individual performance, changes in the organisation of self-regulation, and perspectives on patient safety. This based upon an assumption that if it is possible to control the medical performance of doctors, especially through appraisal, then there should be some evidence of changes in their performance.

Impact of appraisal on individual performance

The ultimate objective of appraisal is to make a positive impact on individual performance and improve the quality of patient care. "The presupposition of appraisal is that the NHS goal of improving patient care will be met by allowing staff to identify and fulfil their own development needs because the organisation and the staff share the same goal. We now have evidence that this is a legitimate assertion: the challenge is to develop appraisal to fulfil this potential" (Conlon, 2003: citing West *et al.*, 2002). The survey results were examined for evidence of its effectiveness as a mechanism for change. The answers to some key questions are summarised in Fig. 5.2 in which both Grades have been aggregated, with the relative response rates included.

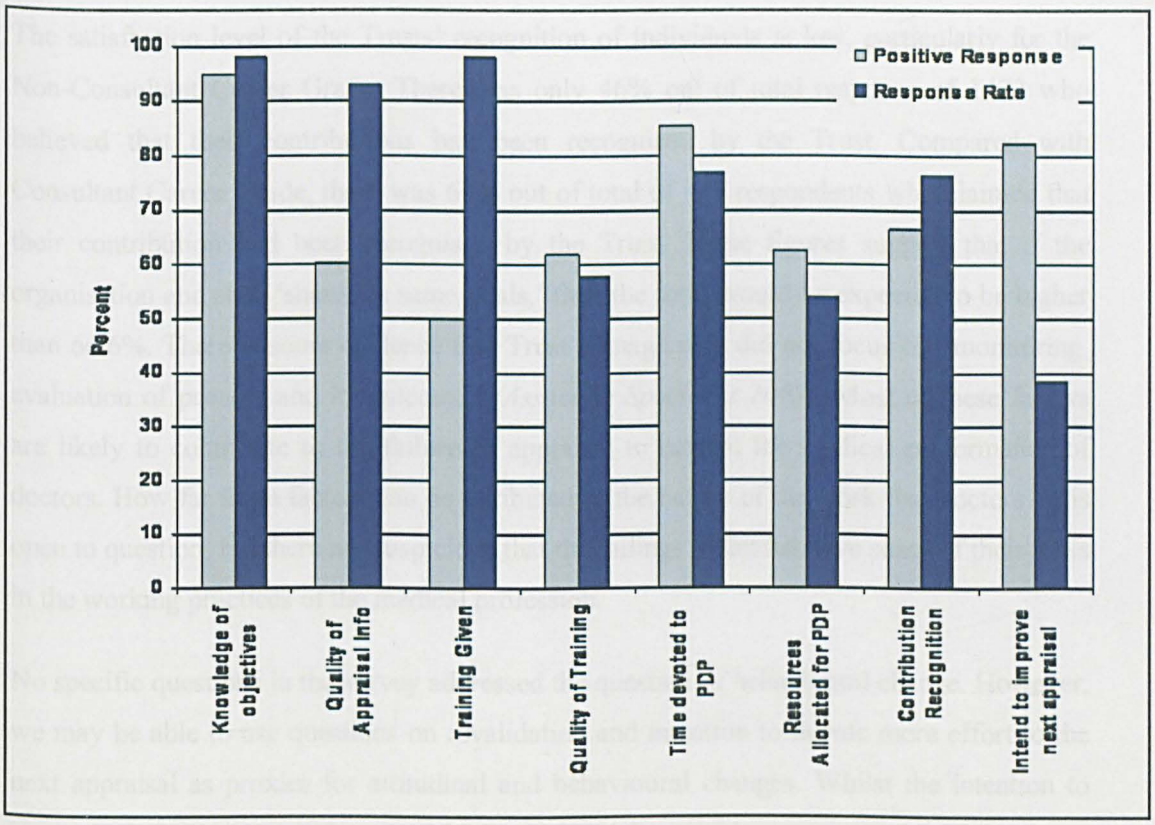

Fig. 5.2 Aggregated summary of survey factors potentially relevant to the change process

It would seem that there are many concerns about the implementation of appraisal to the extent that its effectiveness as a potential agent of change is seriously compromised. Whilst the respondents were clear concerning the objectives of appraisal, the support given in terms of the quality of information available and the training given did not receive high ratings, although the response rate was high, except to the question about the quality of training. Whilst the appraisal allowed staff to identify their own development needs in respect of the time devoted to Personal Development Plans (PDPs) (85.5%), far fewer staff were satisfied with the level of resources allocated to the satisfying of these needs (62.7%).

One respondent claimed, "I get appraisal every year. Every year I was promised an associate specialist grade (for the last three years) still nothing happened. It is the same talk, the same time-waster" *(Staff Grade Cardiologist 1421).* Another observed, "Plans for improvement can only be made and targets met if you change the way in which we work. Non-Consultant grades are not in the position to achieve this" (*Staff Grades 2182).* Other similar comments imply that inappropriate control mechanisms, such as appraisal, to tighten up the control of medical professionals in the NHS, may contribute to lower morale. Indeed, some respondents indicated that they intended to leave the NHS.

The satisfaction level of the Trusts' recognition of individuals is low, particularly for the Non-Consultant Career Grade. There was only 46% out of total response of 1423 who believed that their contributions had been recognised by the Trust. Compared with Consultant Career Grade, there was 61% out of total of 417 respondents who claimed that their contribution had been recognised by the Trust. These figures suggest that if the organisation and staff 'share the same goals,' then the level would be expected to be higher than 66.6%. There is some evidence that Trust management did not focus on "monitoring, evaluation of process and its outcome" *(Associate Specialist 1093).* Most of these factors are likely to contribute to the failure of appraisal to control the medical performance of doctors. How far these factors can be attributed to the nature of the work that doctors do is open to question, but there are suspicions that the failings indicated have some of their roots in the working practices of the medical profession.

No specific questions in the survey addressed the question of behavioural change. However, we may be able to use questions on revalidation and intention to devote more effort to the next appraisal as proxies for attitudinal and behavioural changes. Whilst the intention to improve the next appraisal seemed high (82.2%), the actual response rate of 38.3% was very low and this would suggest that the internal validity and reliability of this response is suspect. One key objective of appraisal was clearly stated by a respondent, "Make appraisal actively change things for the better" *(Staff Grades 0782).* Nevertheless the responses to the question shown in Table 5.9 were the worst response to any question analysed. It would seem that only 529 respondents of both Grades out of a total of 1840 intend to do something differently to improve the next appraisal; this represents 28.8%. The answer, as Robson argues, "may owe more to some unknown mixture of politeness, boredom and a desire to be seen in a good light than to their true feelings, beliefs or behaviours" (Robson, 2002: 231).

Table 5.9a whether respondents intend to improver their appraisal preparation next time
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Non-Consultants	645	0.00	2.00	0.8233	0.44206
Consultants	98	0.00	2.00	0.8367	0.39829
Valid N (listwise)	98				

Table 5.9b Explanation whether respondents intend to improver their appraisal preparation next time

Non-Consultants				Consultants	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No thing	130	20.2	27	17.3
	Yes	499	77.4	80	81.6
	Don't know	16	2.5	1	1.0
	Total	645	100.0	98	100.0
	Not stated	827		309	
	Total	1423		417	

Table 5.9 whether respondents intend to improver their appraisal preparation next time

Some respondents expressed less enthusiasm for future appraisals, with one claiming that "I wouldn't put much effort in as it [appraisal] was just a paper exercise, a formality really. It is a total waste of time" *(Staff Grade Psychiatrist 1386),* and another "wouldn't bother preparing anything, as all my evidence was glossed over and not heard" *(Associate Specialist 1150).* On the other hand, some respondents said they would spend more time and effort to prepare for it, but doing so by spending less time with patients. Some of the respondents expressed the opinion that they would not put a lot of effort into preparing future appraisals, because the appraisal itself does not change much within the Trust, and appraisal is just another form of paper exercise – a waste of clinical time. It "take[s] too much [doctor's] time away from clinical work" and does not achieve much change thereafter *(Associate Specialist 1336).* As one Consultant claimed, "I would cancel several clinics rather than waste my own time on this" *(Consultant Dermatologist 306).* Some respondents show that they will 'help themselves,' regarding the time allocated to data collection and training. More positively, one suggested that they should "re-establish our NCCG peer group forum to share experience and expectation" *(Staff Grade 0710).*

Several instances of negative impacts of appraisal on performance for a variety of reasons were stated. Both Grades identified some inadequacies in current appraisal processes, which they believe may have negative impacts on professional performance. One consultant found appraisal a negative experience because of incompetent appraisers "who don't have an understanding of the nature of my work and aren't interested in my work at all. Such an appraisal does more harm than good to the individual professional performance" *(Consultant 002).* Another believed that the original idea of introducing appraisal into the NHS was to improve the performance of doctors, but was "not convinced that this has been the case and I think in some Trusts it may have had a negative effect where they have used it to get at individuals" *(Paediatrics Specialist 010).*

Other causes of the negative impact of appraisal on the professional performance were stated as it having been "heavily politically driven. The bad press is not good for the professional" *(Rheumatology 007)* and the view that it might not work effectively in all disciplines in the NHS, for example, "in rheumatology it would be very difficult to assess performance through appraisal. It doesn't work well. It might be OK in surgery or specialities where you can easily count things, but in specialities like rheumatology it needs an element of observed practice" *(Rheumatology 008).*

On the other hand, some interviewees expressed positive views regarding the appraisal process and its impact on professional performance. It makes people reflect on their own performance and to explore just how they are doing their job, in terms of improving their performance, through having facilitated self-reflection and clarified development paths. One claimed that appraisal "has helped me to develop more skills e.g. computer skills. It has changed priorities away from service commitments towards education" *(Anaesthetics Specialist 009).* Another regarded appraisal as "better than other duplication of all the relevant facts and information. It would be OK for the GMC to use appraisal in the revalidation process, but recognise the potential conflict between its use for personal development and assessment" *(Ophthalmology Specialist 005).* One implied appraisal could be an alternative form of further career development, "as a senior clinician at the top of the ladder there was no career for further development, and maybe appraisal, done well, can provide this in some form" *(Paediatric Cardiology 008).* The failure of implementation of personal development after appraisal may have a negative impact on the professionals' perception of appraisal as a mechanism for change or as a control tool, ostensibly designed to improve performance.

One consultant has pointed out that the quality of his/her appraisal was ineffective, because "the appraiser has no knowledge of or interest in Ophthalmics" *(Consultant 184).* As another example, one appraisee claimed "My consultant says I have to develop skills relating to Autism - for service needs - but I am not interested in Autism," *(Staff Grade Paediatrics 0863).* A similar point about specialisms is made by another respondent, who stated that "NCCG appraisal should have been relevant to the speciality. What is the point in having a GMC non-specialist registration and working in only one speciality? I knew this is not something that can be alleviated at Trust level. It's a wider NHS problem" *(Associate Specialist 0721).* It seems that doctors do not feel confident that "management is fully aware of appraisal, the clinical significance" *(Staff Physician 0898).* These comments seem to indicate the failings from not appreciating the nature of the doctors' work.

One interviewee agreed that appraisal had been generally developmental within the Trust, regarding appraisal as helping various medical professionals by "keeping in touch with the house practice that is going on... In the morning you do certain things and they do certain things, there is no connection in between, but now there is an inter-connection there. They know what you are doing and you know what they are doing" *(Associate Specialist 002)*. This positive outcome of appraisal, namely those colleagues look out for each other and know what each does, may provide a self-regulating horizontal control mechanism, or clan control.

One impression gained from the analysis of the questionnaires is that appraisal has produced little change except in the lowering of staff morale and that most of the interviewees indicated that they did not believe that the appraisal process has led to a significant change but has had some impact on professional performance. The analysis does not produce significant evidence that appraisal has an impact on the improvement of professional behaviour. This might indicate that the way the current appraisal process as conducted lacks incentives for the professional to change, especially given the nature of the work that doctors do, as indicated particularly in the previous paragraph.

Organisational changes and patient safety

If appraisal linked to revalidation is to be an effective NHS control mechanism, it has to be capable of delivering the necessary organisational changes and improve patient safety. However, given the nature of doctors' work, it should be able to recognise the special factors at work in their clinical practices. Interview evidence from both Consultant and Non-Consultant Grades has suggested that, in theory, appraisal is a good thing if it is applied properly. It could be a positive influence for promoting certain changes within the organisations, and should improve patient care by enhancing the process of professional reflection (Myerson, 2001). However, there was evidence that the current appraisal process conducted in some hospitals might be less effective in facilitating organisational changes.

One interviewee clearly stated that the mechanism of appraisal applied in the organisation created conflict between medical staff and management, and therefore any changes would be unlikely to take place within the organisation. The respondent commented, "'Performance by results' is ridiculous. [The government] will reward the large Trusts with more staff and not those trying to improve. By increasing emphasis on targets rather than patients, clinicians have less voice than previously. 'Us and them' is increasing between clinicians and managers" *(Anaesthetics Specialist 009)*. Some interviewees argued that the current appraisal process was more about the critical evaluation of individual performance,

and one interviewee believed that "appraisal is being used in the NHS in the wrong way. It was intended to improve the clinician's performance through a positive supportive developmental process. Instead, it is being used to target individuals with negative criticism with no positive impact on patient care - may even be negative" *(Paediatrics Specialist 010).*

Conversely, in terms of appraisal in general, some respondents considered that the NHS would benefit from appraisal. One pointed out that appraisal "is part of the clinical governance loop. It makes you look at what you are doing, and what you are not doing so well, and that might lead to audit/research in areas you are not happy with. And that ultimately will improve clinical practice" *(Rheumatology 037).* Similarly, appraisal was viewed as "part of the learning and control effort - a natural benefit" in its effect on both doctors and organisations *(Associated Specialist 004).* One interviewee expressed the opinion that appraisal could be used as a developmental tool for NHS organisational change, claiming that appraisal was related to the sharing of learning, improving communication, and more. The interviewee believed that appraisal's function "in other industries is a part of culture change, and in the NHS it makes people more responsible for their actions" *(Consultant 003).*

Another interviewee believed in the importance of implementation of agreed changes after appraisal brings change to the organisation, claiming that "if the doctor's further development needs are identified and if these are then met it will improve their clinical practice and expertise, and improve the quality of clinical care provided for patients" *(Ophthalmology Specialist 005).* One interviewee believed that appraisal can help to improve patient care "theoretically" and "if the appraisal process is done properly, it can impact patient care, but most importantly it can impact on doctors themselves" *(Consultant 001*). But it has to be based on a fuller understanding of the nature of the work that doctors do.

It would seem that recognition of the nature of the work of doctors is not sufficiently taken account of in the overall appraisal process. For example it was suggested that if the doctors' work is to be appraised accurately a "360 degree appraisal is essential" *(Staff Grade Psychiatrist 0860),* and "by allowing 360 degree appraisal, as a significant part of appraisal process" *(Staff Grade 0376).* Whilst the evidence indicated that there was an implicit presumption that appraisals may help the change in the NHS, it almost certainly needs to be combined with other management approaches. As to precisely what these additional measures might be, there was no significant evidence to address this concern. In addition

this was not a research question in this study. However, the matter will be further discussed in Chapter 7 in which further research is proposed.

5.6 Factors working against appraisal as a control mechanism

This section addresses the key research question:

What could prevent appraisal becoming a control mechanism?

From analysis of the questionnaire surveys and coding of the interviews considerable material was found which might indicate the factors which could prevent the use by the NHS of appraisal linked to revalidation as a means of controlling doctors. Perhaps the strongest opposition to appraisal may come from resistance to the loss of professional autonomy, at an institutional level. The second set of factors seems to be reductions in job satisfaction, commitment and motivation, at a personal level, potentially leading to passive resistance. The third set of factors is organisational around the operationalisation of the appraisal process, potentially leading to insurmountable practical difficulties of organising it.

Loss of professional autonomy

Most of the interviewees, both Consultants and Non-Consultants, recognised trends in the NHS control systems, such as performance tables and the way in which monitoring of medical performance is moving away from traditional self-regulation to more open, public and "bureaucratic accountability" (Harrison & Dowswell, 2002: 223). Some interviewees expressed no objection to public accountability, "if it is done in the right spirit" *(Rheumatology 007).* Another declared, "Public accountability is good, but league tables - just ridiculous!" *(Anaesthetics Specialist 009).*

There were some opinions that suggested there is a need for change in the regulation of doctors. One interviewee, discussing the replacement of traditional self-regulation with external scrutiny, admitted that "we have not self-regulated very well at all and I think we've almost [caused] our own fall. If it does come to that, it's our own fault. It's something we're just going to put up with because we are just really bad at regulating people. We've been very bad at weeding out poorly performing doctors. We've been very bad at sorting out inter-departmental problems and regional problems" *(Consultant 001).* The failure to report malpractice was explained thus by one interviewee, "I think in the past most people kept their mouth shut when there have been problems." But regulation within and between doctors themselves is "probably not very practical, but from a GMC point of

view I actually disagree with some of the comments they make. But I think most doctors would be frightened about going to the GMC" *(Associate Specialist 004).*

The criticisms by the doctors of the latest initiatives over regulation and revalidation by means of appraisal may be grouped under the four headings of: detrimental effects on the professionalism of doctors; the ill-conceived manner of their introduction; adverse effects on the morale of those working in NHS hospitals; and the lack of effectiveness of appraisal to achieve what it is purported to do.

Firstly, the detrimental effects on professionalism are considered. Professionalism implies that "the individual practitioner exerts personal control over the technical aspects of his or her work" (Fahey, 1994: 77). Some doctors saw these initiatives, representing shifts in autonomy in terms of regulation, revalidation and other forms of surveillance, as detrimental to the notion of professionalism. This is because self-regulation is one of the essential characteristics of professionalism and professional bodies. In expressing apprehension over increased scrutiny of the medical profession, one specialist was "very concerned about that responsibility [for standards] being taken from Colleges" *(Consultant 003).* Accountability is being taken outside the exclusive realm of the medical profession and is being introduced in a more formal way in the NHS, challenging traditional forms of professional assessment and self-regulation, by doctors keeping an eye on and between each other.

Doctors value their professional autonomy, and some view such control mechanisms, through the appraisal process, as an attempt by management to replace collegial relations between professionals with hierarchical and managerial relationships. It represents an intrusion into the profession, and some think that this is an unnecessary scrutiny. Some interviewees regarded this increase in external scrutiny of the NHS as resulting in a loss of professionalism. Passing on the responsibility for evaluating a medical professional's performance to an outside body somehow weakens their professionalism, and "the hospital management are involving themselves too deeply and causing an atmosphere where people will give up their professionalism to fit the management's way of doing things" and thus will potentially damage the professional's performance *(Consultant 022).*

Secondly, the ill-conceived manner of introduction was commented upon by several interviewees. One specialist argued that the move towards public accountability "has all been taken too far" *(Paediatrics Specialist 010).* Another interviewee went farther, "They seem to have gone from one extreme to the other. Self-regulation has its faults but the

current swing to openness and public accountability has not been properly thought through" *(Rheumatology 007).* An Associate Specialist said "We're being told more and more in respect of guidelines and protocols coming from outsiders or whoever - some politicians - rather than being professional" and "a lot of things happen in the ward and around the ward. Everything there has protocols written in a certain format. They are political and policy issues. They are not always medical ones" *(Associate Specialist 004).*

Thirdly, the adverse effect on the morale of doctors was commented upon by several interviewees. Some suggested that replacement of traditional self-regulation by peer supervision, which might be called a low-trust form of regulation, with a tight control form of surveillance may cause damage to professional morale. This is because "it's all about 'Watch out for you might be doing wrong!' But in return you never get praise for what you do good. You probably never did anyway....and mistakes are more like to happen because you are tired and you are rushed. It is wearing away one's very morale" *(Associate Specialist Dermatologist 003).* One interviewee outlined a possible solution in this way, "One of the major things is that in medicine, we've had to accept the fact that clinical freedom is [being eroded] in many cases. But having said that, if you can justify the way you do something, you should still be allowed to do it. You just need somebody who will pull the whole thing together and see it from 360 degrees and it is definitely difficult" *(Consultant Anaesthetist 007).*

Fourthly, several interviewees commented on the likely ineffectiveness of appraisal linked to revalidation being an effective control mechanism. One doctor pointed that appraisal and validation are not very discriminatory in revealing professionals' performance "to me they are just a paper exercise...we have got bits of paper to say I have been appraised, I have been revalidated. But nobody really knows what I am doing or how good I am. I could just be good at filling in papers. You could be a really bad doctor doing all sorts of things, but it wouldn't show in the appraisal" *(Associate Specialist 003).* One doctor went further by suggesting that the increased scrutiny from outside could be detrimental to the patient.

A few saw the changes in the control mechanisms as still allowing the medical profession to keep control of regulation and to be responsible for revalidation. The interviewee expressed dissatisfied with the regulation of doctors being opened up to the public, although appraisal was considered to be "a part of the regulation. It is a sort of self-regulation because [it is still] within the medical profession itself. It is not somebody coming from outside" *(Associate Specialist 002).*

Changes in professional regulation was the subject of greatest concern to many of those interviewed. Whilst many recognised the problems of self-regulation, there was widespread views around potential resistance to the present approach. Tight external control was felt likely to reduce professionalism and may thereby reduce the quality of patient care. The strategies and tactics that doctors might use to resist these initiatives, outlined in theory in Chapter 3, will be further discussed in Chapter 6.

Satisfaction, commitment and motivation

Interviewees from both Grades commented on the many interventions from government in recent years, for example, target setting, the Patient Charter, the National Institute for Clinical Excellence, the Commission for Health Improvement and the appraisal process, intended to effect changes in the health care system, have to a considerable extent had negative impacts on doctors' job satisfaction, motivation and commitment. The following themes emerged from the coding of the interviews:

- *Greater financial and management control of hospitals by non-medical professionals*
- *Poor manager-clinician working relationships*
- *The introduction of government performance targets, medical audits and quality systems*
- *Inadequate funding and resources*
- *Constant adverse media attention on the profession*
- *Increased threat of litigation*
- *A decline in the status of, and respect for, the medical profession in society*

These issues have implied resistance to change within the NHS. One interviewee provided an example about the new consultant contract, in a document *Clinical excellence awards*, one of the principles of change was awards and incentives, which required that consultants need to show "satisfactory participation in the annual appraisal process" (DoH, 08/2003: Introduction: 4). This informant went on, "there was a contract negotiated, the doctors rejected it, the government decided that what they would do is have a system of either you chose the contract or you could have incentive payments and different styles of incentive payments in different places" and "we have got three or four different schemes now, to implement in a climate where everybody's pretty fed up about what's happened in the last few months and over the pay scheme which was in a climate of a lot of anxiety amongst medical staff about the attitude of the government to them, the behaviour managers were exhibiting around things like targets and that sort of thing, so they knew the government had instructed them, but they still didn't feel that managers were doing what they wanted them to do, and then there is this whole piece of work around morale going on, around the whole compact between the public and medicine" *(Director of 'New Ways of Working').*

This quotation clearly shows the feelings of resentment concerning the nature and manner of introduction of new remuneration schemes. It shows the frustration and dissatisfaction with the way in which government initiatives affect management processes and ignore the needs of the medical profession. This has led to a feeling of disempowerment and unilaterally imposed external scrutiny. Therefore there is an impact on morale and it will also reduce doctors' commitment and damage their motivation. One respondent expressed their disappointment that the appraisal process had been muddled through just as eyewash, because "None of the action plans that were discussed at the appraisal was followed through. It is basically another 'target' that the Trust has to meet to show the government so that they can get a 'star rating'" *(Staff Grade 0573).*

One interviewee has pointed out that appraisal can be good for doctors but commented, "I doubt whether it should be mandatory. It can be a useful developmental tool, but will only work if there is an incentive from the appraisee to act, and the necessary support available for this to happen" *(Associate Specialist 008).* Moreover, some interviewees suggested that if appraisal is conducted inefficiently, it will affect doctors in terms of feeling under-valued, lowering morale and damaging motivation. In particularly, for lower grade doctors, some felt unsupported in terms of training and development in comparison to Consultants. One Non-Consultant said, "Consultants do not automatically recognise and respect the contribution we make ... and so they don't see any need for continuous professional training for staff grades" *(Associate Specialist 024).* One claimed that the appraisal process had a personal negative impact because "I do an awful lot, yet it is never enough for people. They always want to get as much clinical work out of you as possible. And you never get any praise for anything" *(Associate Specialist 003).*

One respondent argued that those government interventions have, to some extent, changed the current medical culture for the worse. For example "Attitudes have changed. The junior doctors have much less commitment to the patients. It is more of a job to them. Something has got lost in the process, and that has had quite an impact on those in the more senior jobs who have to plug the gaps" *(Rheumatology 007).* A similar view was expressed by another interviewee who stated that those intensive changes in NHS in the last decades have caused "striking" changes in the way junior staff perceive the health service. They "don't have as much dedication or devotion to their work. They are much less motivated. They consider it is 'just a job' not a vocation to them. They don't care about the patients like us older clinicians do" *(Ophthalmology Associate Specialist 005).*

From the limited evidence from the interviews it can be seen that like previous government interventions, appraisal was introduced with good intentions but lack of consultation, lack of consideration of professional needs, and lack of harmony between management and clinicians. Increased tensions between the profession and public have all led to a reduction in job satisfaction, damage to personal commitment and the lowering of morale. How far these factors will work against appraisal linked to revalidation becoming an effective control mechanism will be discussed in Chapter 6.

Organisational limitations

Numerous problems with the implementation of appraisal were identified in Section 5.3. It is difficult to judge the extent these were merely teething problems, since this study took place during the earlier stages of the introduction of appraisals for hospital doctors. Some of the issues raised here appear to be more endemic and not the result of inexperience with the appraisal process. However, this can only be judged when this study is compared to similar studies in Chapter 6. There was considerable concern expressed by many respondents and interviewees of both Grades about the operationalisation of appraisal, ranging from questions of fairness, efficiency and feedback to concerns about appraisal data - access, validity, reliability and relevance. The first issue is that of fairness. The evidence has shown that there was a lack of equitable chance to access training, preparation time and appraisal across different clinical directorates.

The first aspect of fairness was that time allocated for appraisal seemed not to be equitable. The actual preparation times varied from less than two to more than seven hours, with Consultants seeming to spend less time than Non-Consultants. This may reflect that the former have easier access to information or they were unable or unwilling to give the time, with several feeling distress at the 'waste of clinical time.' Of Non-Consultant grades, 20.3% pointed out that they have not been give sufficient time to prepare and 69.3% needed more than five hours. This could be because of the lack of training and guidelines. However, 76% of Consultants had enough preparation time (Table 5.21 Appendix E). One Consultant spent 19 hours for the first appraisal "all in my own time at weekends etc., and this year I've spent about 6 hours...I really think it is those sort of futile time-wasting activities which demoralise people and causes resentment and the actual usefulness of appraisal needs serious thought" *(Consultant Dermatologist 306).*

The second aspect of fairness relates to the different emphasis given to different grades of doctor, with lower ones given less priority. One respondent said, "I feel that the Trust is more enthusiastic when it comes to consultants and juniors, but welfare of middle grades

[is] grossly neglected" *(Staff Grade 0642).* One has claimed that "nothing [is] organised at all for staff grade doctors to my knowledge" *(Staff Grade 0666).* And one locum doctor claimed that "I am not entitled to participate in appraisal as a locum doctor. As a locum doctor it will be difficult for me to fulfil the criteria to get revalidated" *(Locum Staff Grade 0492).* Evidence shown that in some Trusts appraisal had "very patchy implementation for staff grades" *(Associate Specialist 0930).* "As usual Associate Specialists receive better treatment than Staff Grade and Trust Grade" *(Associate Specialist 1293).*

The third aspect of fairness concerns power gradients between appraiser and appraised. Doctors said that they felt it difficult and unfair to be appraised by their immediate superiors, especially where there may be relationship difficulties. The unfairness at appraisal was described by one respondent, who felt their experience was being "terrible, totally demoralised" because there was no listening, just "simply asked to obey them" *(Staff Grade Paediatrics 0863).* The negative experience of the appraisal was described as more of a "leg pulling" session than appraisal *(Staff Grade 0871).* Others found the process fair, but not open. For example, "There was the constant feeling (which I am unable to substantiate) of a 'hidden agenda'" *(Staff Grade 1416).* Suggested solutions were "an independent superior present at the appraisal" *(Trust Doctor 1377),* and that "there should be a choice for everyone to choose a suitable appraiser" *(Senior Community Paediatrician 1269).*

The final aspect of fairness concerns the communications between Trust management and the various levels of medical staff, which might cause the appraisal process to be ineffective and unfair. Therefore, there is a "need to improve communication between Trust and medical staff" *(Staff Grade Psychiatrists 0972).* One respondent expressed such communication difficulty clearly: "I have a good relationship with my named consultant but if this were not the case, I could see it would be difficult for others to get their concerns voiced at a high level" *(Associate Specialist in Dermatology 0980).* The respondents suggested that the lack of a standard format and structure might create unfairness between Consultant and Non-Consultant Grades, because "the Trust is using the same appraisal process set for consultants to appraise the NCCG doctors" *(Staff Grade 0937).* Trusts may prefer to involve Consultants over lower grades. "Onus is on consultants' appraisals due to gaining star status. So NCCGs are not encouraged enough and their appraisals are delayed" *(Associate Specialists 0639).*

The second major issue concerns efficiency and feedback, identified by the respondents as inadequate support structures provided by management, lack of clear procedures, an

absence of a practical guide and inconsistencies in the system. Some respondents highlighted the Trusts' "lack of appropriate IT tools and support" *(Associate Specialists 0892).* "I am not sure for certain as to whether the process is likely to change circumstances within the Trust as limited resources and constraints within the infrastructures determine the ability to fulfil expectation for the future" *(Staff Physician 0799).* For example, "senior staff are still unclear who should do appraisal" *(Staff Doctor 0883)* and "many clinical directors haven't got a clue about SAS jobs" *(Associate Specialist 0908).* One Consultant pointed out that "the format is very user unfriendly – confusing, repetitive, bureaucratic etc" *(Consultant 140).*

The efficiency of appraisal to some extent depends on the time and attention devoted to it and evidence suggests that sometimes the matter was given scant attention. Some NCCG respondents complained that it had not been taken seriously by the appraisers. Some claimed that much time was spent on data collection, but some appraisals were just 'rushed through' and 'done rapidly' - "only 30 seconds to discuses with my consultant in appraisal" *(Staff Grade 0878),* and "it was just a formality, completed in five minutes" *(Associate Specialist 0084).* Another recalled, "it was not taken seriously by the appraiser who made it clear that he wanted to rush through it to get it done. There was no two-way discussion as I had hoped - more of a monologue by me with which he nodded assent" *(Associate Specialist 1275).*

The lack of clear and standardised procedures is illustrated by the following comment: "No universal agreement on objectives and the professional development plans" *(Associate Specialist 0930).* The procedure for the collection of relevant information "does not appear to be standardised and is often up to the individual to ensure it is a structured and thorough process" *(Staff Grade A & E 0791),* and one respondent was concerned about the accuracy of the information collected *(Staff Grade 0280).* There was a call for a standardised appraisal form for both CCG and NCCG, since it seems that the current format is biased towards the interests of Consultants, as one interviewee indicated, "a lot of information asked is only relevant to consultants" *(Staff Grade ENT Surgeon 0775).*

One issue was raised about the consistency in the conduct of appraisal and there was evidence from the survey of a lack of formal training in conducting appraisals, for both appraisers and appraisees, which undermined confidence in appraisal. One respondent recommended, "Standardise approach to training appraisers and appraisees. Ensure everyone is appraised by someone they can relate to and who understands their professional discipline" *(Staff Grade 0798)* and the Trust should be "considering equal opportunities"

for training for all medical doctors in appraisal *(Staff Grade 0817).* The survey has shown evidence of a lack of feedback after appraisal, from peer groups, management and from the appraisal process. Some respondents addressed the need for "feedback, both positive and negative" after being appraised *(Associate Specialist 0784).* There was concern about the lack of a systematic procedure to evaluate Trust performance in terms of effectively implementing the appraisal. Feedback was excluded from the appraisal. "The Trust has no formal feedback form from patients and colleagues" *(Staff Grade Psychiatrist 0813).*

The third major issue concerns the reliability, validity and relevance of the data collected or needed and the difficulties of obtaining such data were commented on by both Grades. Table 5.10 presents concerns about whether valid and relevant supporting evidence had been presented and discussed at appraisal. 81.4% out of a total of 975 Non-Consultant Grades responded positively. Whilst the positive response from Consultant Grades was high at 75.2%, the response rate at 133 (31.9%) was very low. Reasons offered for lack of satisfaction were:

- *Lack of discussion*
- *Little evidence presented*
- *Lack of time to collect data*
- *Relevant data unavailable*

Table 5.10a Whether valid and relevant evidence was presented and discussed at appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Non-Consultants	975	0.00	3.00	0.8636	0.46528
Consultants	133	0.00	3.00	0.8120	0.50976
Valid N (listwise)	133				

Table 5.10b Explanation whether valid and relevant evidence was presented and discussed at appraisal

Non-Consultants				Consultants	
		Frequency	Valid Percent	Frequency	Valid Percent
Valid	No	165	16.9	30	22.6
	Yes	794	81.4	100	75.2
	To some extent			1	.8
	Not sure	16	1.6	2	1.5
	Total	975	100.0	133	100.0
	Not stated	448		284	35.6
	Total	1423		417	

Table 5.10 Whether valid and relevant evidence was presented and discussed at appraisal

Concern was also expressed about the lack of cooperation between different departments and the lack of resources in accessing the necessary data. Non-Consultants showed

considerable concern about the reliability and relevance of the data presented and discussed at appraisal. There were comments that there was no written evidence available in some Trusts. Some of the respondents expressed the opinion that insufficient evidence had been given by them in appraisal. One respondent claimed that it was "impossible to get accurate information from clerks, regarding numbers of patients seen etc, still very minimum IT for clinical audit use" *(Associate Specialist 0942).* "The relevant information seems to have reached only certain parts of the medical staff" *(Staff Grade Psychiatrist 0972),* and other problems of obtaining relevant data were due to "clerical and administrative deficiencies in departments" *(Staff Grade 1174).* Many appraisees had to collect data only from their own records because evidence was unavailable. Consultants also struggled to access data. As one informant pointed out, "There is little access to certain statistical data regarding patients seen just by me" *(Senior Medical Officer 0693).*

In summary, this section has identified those factors, identified by survey respondents and interviewees, which might militate against the use of appraisal linked eventually to revalidation as an effective NHS control mechanism for the performance of doctors. The most frequent argument put forward related to the loss of professional autonomy, despite it being recognised that self-regulation has its faults. The loss autonomy may bring a reduction in professionalism and a lowering of morale which might have the unintended consequence of actually reducing the quality of patient care. Many responded to questions on the effectiveness of appraisal as a means of identifying poor performance somewhat negatively.

The mandatory introduction of appraisal was identified by several as leading to resentment, the under-valuing of doctors' contributions to healthcare and less commitment to patients. In its introduction, appraisal was said to be unfair for many grades of doctor, not efficient and based of data that were incomplete, inappropriate or lacking in validity. The lack of formality and uniformity in the appraisal process and procedures shows that the policy could easily allow discrimination and prejudice to seep into the system. Therefore, there is some opportunity for people to be treated unequally. Failure to deliver developmental outcome for doctors was seen to have negative impacts. "If expectations of development are raised but not fulfilled, the implications for consultant motivation and performance are likely to be negative" (Simmons & Eades, 2004: 159).

Thus there seem to be a variety of factors that may prompt doctors to resist, probably mostly passively, the use of appraisal linked to revalidation as a control mechanism in the

NHS. The strategies and tactics that might be relevant were discussed in detail in Chapter 3 and these will be further explored in the next chapter.

5.7 Conclusion

This chapter has focused on the preliminary analysis of two sets of data, the questionnaire surveys and the semi-structured interviews, which targeted Non-Consultant and Consultant Career Grades within the NHS in England, conducted in 2005 - 2006. The analysis has been organised thematically around the various research questions, with the main focus on the central issue of the extent to which the government is able to control the medical performance of doctors through appraisal, probably linked to revalidation of the licence to practice.

The functionality of appraisal was recognised by most informants and the tensions between the summative and formative functions were articulated by several. Respondents from both Grades provided rich evidence about how medical professionals perceived appraisal in terms of its functionality for professional development, in respect of personal development plans. From interview evidence it is clear that many respondents regarded appraisal, at least in theory, as having the functionality and potential to help professional development by, for example, keeping in touch with in-house practices and being more connected to other colleagues. It could lift the professional spirit, as one first-time appraisee reported, "the appraisal gave me some insight into my strength which encouraged me go further in terms of the career ladder" *(Staff Grade 1090)*. On the other hand, another argued that it is "very much service oriented, not much place for career improvement" *(Staff Grade 1121)*.

However, in many cases the resources were lacking for the realisation of doctors' personal development. Several informants claimed that the formative function of appraisal needs support from Trusts, some of whom have failed to implement this support fully or efficiently. Others described disappointment with the ritualistic nature of appraisal, whilst others suggested that there are different means available to foster personal development. Other criticisms suggested that appraisers tended to concentrate on development of their technical performance to the detriment of softer skills. Several respondents believed that appraisal should also recognise their contributions to the NHS, a subject not covered sufficiently in the literature. Indeed, 28.7% of Non-Consultants and 34.6% of Consultants felt their personal contributions were not adequately recognised.

The research indicated that such failure has to some extent led to negative motivational consequences, particularly in the Non-Consultant Career Grade doctors, whose individual contribution to the Trust has failed to be recognised. It has to some degree damaged the professionals' self-esteem. Pearce & Porter (1986) referred this "performance appraisal touches on one of the most emotionally charged activities in business life - the assessment of man's contribution and ability. The signals he receives about this assessment have a strong impact on his self-esteem and on his subsequent performance."(Thompson & Dalton 1970: 150, cited in Pearce & Porter, 1986: 211). With these negative experiences of the appraisal process, it might be inferred that the linking of appraisal to revalidation can lead to doctors missing the opportunity to make use of the positive aspects of appraisal that are "confidential, developmental and formative" (Cavendish, 2003:4) for their own and their organisation's development. Overall, the formative function of appraisal as constituted might create stress, suspicion and disappointment amongst some doctors.

Issues around the quality of the implementation of appraisal were comprehensively explored in the data in respect of awareness of its aims, personal history of appraisal, quality of advice, information and training provided and the time allocated to it. The most significant theme to emerge was the disparity between different grades of doctors, with a far greater emphasis on Consultants to the detriment of Non-Consultants. This has created inevitable competition between Grades for resources. Such an approach towards appraisal also reinforces the power gap between grades. Thus appraisal may generate new forms of additional intra-professional power within career grade doctors and may lead to intra-professional conflicts within the NHS. Therefore, it calls into question the fairness of communications between management and the various levels of doctor.

Both Grades have identified a range of problems in implementing appraisal within the NHS. The efficiency of the process was questioned: support structures were missing, procedures were unclear and the absence of practical guides, especially for lower grades, led to inconsistencies. These included concerns about inequity in the treatment of different grades and the need for 360 degree appraisal and greater standardisation. The validity, reliability and relevance of the data were all questioned and problems in accessing data from other departments were identified as a major concern. This evidence may suggest that if any real benefit is to accrue from the appraisal process much adjustment needs to be made to how it is implemented.

The use of appraisal as an NHS control mechanism imposed by the government was recognised by many of the survey respondents and interviewees. This emphasises the

summative nature of appraisal and its supposed use as a means to recognise poor medical performance and to link it to revalidation of the licence to practice. Doctors recognised that the monitoring of medical performance is moving away from traditional self-regulation to more open, public and "bureaucratic accountability" (Harrison & Dowswell, 2002: 223).

Its political nature as a government response to the spate of adverse events was well recognised as "political cosmetics" *(Consultant 104)* to demonstrate that the government was doing something to address the concerns of the public over high profile medical malpractices. Some doctors went further by suggesting that a few rogue doctors had precipitated the initiative and that all doctors were to be made the victims of external scrutiny. This politicisation was seen more of a cosmetic exercise than confronting fundamental weaknesses and a suspicion that appraisal was one means of imposing external regulation.

As a means of recognising and rooting out poor medical performance its utility was strongly called into question and it potential considered to have been overestimated. Appraisal was seen as "a sledgehammer to crack a nut" *(Consultant 003)* and as, "A routine procedure. Not very person-specific. Fairly superficial" *(Staff Grade A&E 1264),* rather like rubber stamping. There was no strong evidence from either Grades that the appraisal process could function effectively as a measurement tool to identify poor performance. It would, in the opinion of many, not succeed in unearthing rogue doctors, because "an incompetent, psychopathic or criminal doctor could easily perform a 'good' appraisal" *(Consultant 184).* Overall, poor performance is too multi-faceted to be solved by one means.

The issue of linking appraisal to revalidation as a strengthening of the control system received different response from the two Grades, with Non-Consultants giving less evidence of concern and Consultants raising more questions about it. The concerns were about the rigour and fairness of the process and the competing objective of appraisal for development support and its use as an assessment tool as part of a control and monitoring mechanism. The system relies on individual honesty and would probably fail to pick up another Shipman and doctors that pose a risk to patients. Overall the existing appraisal system with its link to revalidation was felt as threatening by some and lacking in equity, impartiality, rigour, efficiency. It was felt to be too politically motivated to be of real utility in contributing to revalidation and its fairness compromised by politicisation.

The question of how far it is actually possible to control medical performance given the nature of doctors' work was only partially addressed by the data. Proxies were used to code the data around behaviour changes in clinical practices prompted by appraisal and organisational culture changes that would deliver improved patient safety. Much of the evidence was implicit and found in the sub-text of interviews. Several doctors questioned the validity of the information used and its objectivity especially in non-surgical disciplines such as anaesthetics. Measurement issues were raised, including the evaluation of the doctor/patient relationships. Some saw the process as an expensive paper exercise unsuitable for the medical profession and less valuable than peer review. Because of the weak evidence base around this research question proxies were created. The first was the potential changes in medical behaviour promoted by the appraisal process and the second was its potential for cultural changes in the NHS deemed necessary by Donaldson *et al.* (2000) to tackle adverse events and improve patient safety. A further proxy was the intention of doctors to devote more time and effort to appraisal in the future.

Both grades felt that the appraisal process does little to change medical behaviour and said that their appraisal would make little improvement to their performance, though some thought that it might have the potential to do so. Several expressed lack of confidence in the system which seemed to emphasise service needs rather than addressing the actual individual work that doctors do. So much so that only 28.8% of respondents said that they will do more work for their next appraisal. Some were more critical arguing that it consumes much clinical time, generates much paperwork "but it changes nothing" *(Consultant Orthopaedic Surgeon 036).*

The interviews reinforced the finding from the questionnaires that appraisal has not so far effected much significant change within the NHS as whole, but that there has been some impact on individual medical professionals. Some of them believed appraisal would help for further career development by facilitating reflection on personal performance and identifying paths for such development. There was some evidence to show that the current appraisal process was less effective in helping the organisation to change, with one consultant stating that appraisal "will not bring any change within the NHS *(Consultant 104).* Some viewed appraisal as being driven politically and would thus not help the NHS to deliver its own changes. One respondent suggested that the failure to implement plans after appraisal in some Trusts would make changes less likely within those organisations. Some suggested that performance by results would do little to improve patient safety, as these measures make little recognition of the work which doctor actually do.

The final section on the factors which might prevent appraisal linked to revalidation becoming an effective NHS control mechanism found considerable data on the issue. The three emergent themes are: the potential for resistance due to loss of professional autonomy; the likelihood of passive resistance to appraisal due to possible erosion of job satisfaction, commitment and motivation; and the endemic organisational limitations that its operationalisation seems to have brought with it, potentially leading to insurmountable practical difficulties of organising it. Respondents from both grades showed they were aware of the current problem of self-regulation, with its several loopholes, and some of them expressed concern over increased pressure for external regulation. Nevertheless several interviewees expressed no objection to public accountability, done in the right spirit. However, change in professional regulation was the subject of greatest concern to many interviewees. Whilst many recognised the problems of self-regulation, there was widespread resistance to the present approach. The strategies that doctors might use to resist these initiatives, outlined in Chapter 3, will be discussed in Chapter 6.

The loss of autonomy, tight external control, the replacement of collegial relations between medical staff by a managerial and hierarchical control system was felt by many to be eroding professionalism, lowering morale and seen as a retrogressive step, which might have the unintended consequence of actually reducing the quality of patient care. Several interviewees identified negative impacts on doctors' job satisfaction, motivation and commitment leading potentially to passive resistance. Others identified the plethora of government interventions as changing newer doctors' attitudes to patient care for the worse.

The mandatory introduction of appraisal was identified by several as leading to resentment, the under-valuing of doctors' contributions to healthcare and less commitment to patients. Nevertheless, the data only provide limited evidence about these concerns. In its introduction, appraisal was said to be unfair for many grades of doctor, not efficient and based of incomplete, inappropriate or invalid data. Therefore, appraisal as an effective control tool to monitor professionals' performance has been shown by some evidence to be too weak because of its current design. One respondent described it as "lots of paperwork, and centrally-planned but poorly coordinated" *(Staff Grade Paediatrician 1048).* Other identified issues of consistency, bias, formality and absence of patient and co-worker feedback. Appraisal lacks the ability to promote real change since insufficient senior staff with power and influence are directly involved and is too haphazard.

Whilst some interviewees suggested that there was an implicit presumption that appraisals may assist in changing culture in the NHS if it is combined with other management tools,

there was no significant evidence to show that such results had in fact been achieved. Further evaluation of the impact of appraisals over time is needed. In addition, one comment merits further analysis: "I think there is too much overlap, repetition between the various sections. The whole process would be carried out just as effectively with a less cumbersome system. I am not sure that the current process will achieve the proposal aims" *(Staff Grade 0041)*. This might suggest that appraisal needs to be integrated more carefully into a range of systems for controlling the performance of doctors and to give greater recognition to the nature of the work that doctors actually do. This issue will be raised in Chapter 6.

The next chapter will further discuss the findings in relation to the above data and integrate them with theoretical aspects, to ascertain the degree of fit between them. Having reviewed similar studies often with different conclusions, the chapter reviews the current governance structure and proposes a tentative framework to address the deficiencies in the control of medical performance identified in this research.

Chapter 6

FINDINGS AND DISCUSSION

6.1 Introduction

The relationship and tensions between professional autonomy and management, and the perceived impact of these tensions on service quality and professional knowledge as a source of power have been the key themes of this study. The literature review focused on the nature and causes of the tensions between professional self-regulation and direct control, and the perceived need within the NHS to shift 'professional autonomy towards a system of 'responsible' autonomy (Friedman, 1987; Dent, 2005). One of the key concerns at the heart of this policy is about questions concerning doctors' ability to manage the existing traditional form of self-regulation and to evaluate their own performance without accountability to others (Harrison & Downswell, 2002).

Control of the NHS has traditionally been the preserve of the medical professionals, and evidence from the literature (Chapter 2 & 3), interviews and questionnaires (Chapter 5) have shown that there is concern among doctors over the conflict between professional power and management control. The value system is the core of professional autonomy, which is reflected in the concept of medical professionalism, as it requires "observance of explicit standards and ethical codes" by doctors reinforced by "a high degree of self-regulation over professional membership." Society generally accepts that doctors can be trusted to "act responsibility without supervision."(Rosen & Dewar, 2004:12), though this now seems to have been challenged.

Medical professionals believe "their work is characterised by highly specialised knowledge and skills that are impossible for the laity to comprehend or evaluate" (Sutherland & Dawson, 1998: 19). The nature of medical knowledge has created the basis upon which professional autonomy rests - clinical practice based upon tacit knowledge as well as professional knowledge and skills (Polanyi, 1969; Freidson, 1970; Dawson, 1995; Sutherland & Dawson, 1998).

During the Shipman inquiry, Dame Jane Smith examined the General Medical Council's proposals for revalidation and the links to clinical governance and "the potential that two processes will have for the detection of poor or aberrant clinical performance" (Smith,

2004: 1027). She suggested that if revalidation were properly implemented, it would "achieve two objectives: the weeding out of poorly performing doctors so as to protect patients, and the enhancement of performance in others" (op. cit.: 1030).

The chapter is organised as follows. Section 6.2 considers the various concepts and theories of control and assesses the interactions between theory and practice to find how far the theories and data fit together. Section 6.3 reviews similar studies on control of medical performance, appraisal and revalidation and identifies the similarities and differences in the conclusions. Section 6.4 directly addresses the main research question about the extent to which the government can control the clinical performance of doctors through appraisal. Section 6.5 identifies the current governance structure in the NHS using Mintzberg's five elements of organisational configurations and assesses its limitations and disadvantages, before proposing a new framework for use as a conceptual tool to promote dialogue around the resolutions of the contradictions found in the current model.

6.2 How theories interacts with the data

This section tests the theories and concepts on bureaucratic and clan control, on responsible versus professional autonomy, on (post-) bureaucracy interacting with mock bureaucracy, and on panoptic surveillance versus the power of medical knowledge against the survey and interview data. The intention is to determine the degree of interaction between theory and practice. It was found that the various concepts are linked, as for example responsible autonomy is a manifestation of the move towards post-bureaucracy and that mock bureaucracy and its mechanisms relate to reducing the power of panoptic surveillance.

Ouchi

The distinctions between bureaucratic control and clan control suggested by Ouchi were only implicitly confirmed in the data. Doctors indicated their perceptions of bureaucratic control being driven politically. The NHS may be seen as a classic example of a centralized bureaucratic organization with politicians at the top seeking to control the behaviour of staff in the operating core by centralized planning, national standards and legislation. Evidence from the data indicates that informants were well aware of the desire for control by politicians. Several recognized the pressure on politicians from the cases of medical malpractice which prompted them to increase bureaucratic regulation.

For example, because of Shipman "so then all the GPs are subject to control by the government" *(Associate Specialist 004)*. Similarly, the Bristol Royal Infirmary case meant

that "everybody else is paying the price" in terms of satisfying "the interests of the Department of Health, and the control they want to exercise to bring everyone into line" *(Associate Specialist 001)* and the fact that one specialist recognised that this case prompted the introduction of revalidation such that, "Extreme cases make bad precedence" *(Associate Specialist 001)*. Bureaucracy at work was identified by an informant when he suggested that appraisal is "probably an unnecessary reduplication for political and bureaucratic reasons" *(Professor of Pathology 284)*. The bad press around medical malpractice has had adverse effects on doctors since this has led to a reinforcement of bureaucratic control, which has been "heavily politically driven" *(Rheumatology 007)*.

Bureaucracies tend to defend themselves from external criticism by the use of rational evidence. Appraisal may be seen as a bureaucratic defence "enabling the organization to provide a satisfactory account if called upon externally" and one that is "difficult to assail legally" (Barlow, 1989: 513). Moreover, the data show that this desire to use appraisal as a defence mechanism has led to the tendency to demonstrate the best and seek to hide the worst. The extract below shows how any criticism regarding poor performance and recorded on paper in appraisal gives a warning light to management with an implicit hint that the information should be screened out:

> *"Very poor performance is usually in the lower grades. It annoys me because there was nothing on paper but now the trust administrator has swung right round and any hint on any paper about any poor performance just stops people working. It's happening regularly, [but] not in large numbers."*
>
> (Consultant 015)

The tensions between bureaucracy and clan in the NHS were confirmed at least partially in the data. This was found particularly in the issue of surveillance, said by Ouchi to be a fundamental means of bureaucratic control. Parker (2000: 230) argued that if staff believe that they are valued then this motivates hard work and "disposes of the need for visible, and potentially costly, technologies of control." This concept emerged from the data in a negative form since many respondents expressed concern that appraisal failed to recognise the value of their personal contributions to their Trusts. One telling observation was that, "I feel the Trust is unaware of my existence other than as a small statistic" *(Staff Grade 1413)*. Further, "Middle grades are the invisible work force in the Trust and their work undervalued" *(Staff Grade 0642)* and one doctor admitted, "I am used to little recognition from senior colleagues and the system" *(Staff Grade 1389)*. These remarks may suggest Ouchi's (1983: 85) view that bureaucratic control leads to "alienation, anomie," leading to such comments as, "You rarely get the praise" *(Consultant 015)*.

It has been argued that higher quality of service be generated if doctors are left "to develop their own particular quality sub-cultures" (Hart, 1997: 266). This would suggest clan control but the evidence from the data around this is limited to comments on the greater benefits of peer review compared to top-down appraisal. For example:

> *"Certainly within A & E where we work very closely with each other, it is important that there is a place where people can express their opinions that things are going wrong."*
>
> *"After a cardiac arrest, if things haven't gone well, we'll talk about it."*
> (A & E Doctor, 065)
>
> *"We should re-establish our NCCG peer group forum to share experience and expectation."*
> (Staff Grade 0710)

Whilst the data are very limited on clan control, Ouchi's concepts were nevertheless found to be informative on the landscape within which the struggles for control of medical performance were situated. Doctors were prepared to comment on bureaucratic control but rarely commented on clan control. This absence of data might suggest that a different representation of Ouchi's concepts should be considered. His conceptualisation might be mediated by Fahey's (1994) three models of medical control. These are: autonomous which is based on clinical independence, represented by clan control; heteronomous in which doctors are subordinate to an administrative framework, represented by bureaucratic control; and conjoint where the professional and administrative hierarchies have equal power and importance of function. This will be brought together in Section 6.5

Professional autonomy and responsible autonomy

Here the data fits more readily with the concepts and theories of responsible autonomy and professional autonomy. Friedman's (1977) concept of responsible autonomy replacing direct control has been identified in the data and juxtaposed against professional autonomy. Professional autonomy, defined as "control over a particular body of knowledge in terms of its creation (research), transmission (education) and application (performance)" (Salter, 2004: 70) and epitomized by self-regulation, was regularly commented upon by the survey respondents and the interviewees, who recognized its limitations in a changed environment. The response to the threat of de-professionalisation was not "to hark back to some halcyon days of professional dominance but to recognise that in the new climate there are certain limits to clinical freedom" (Armstrong, 1990: 692). Bate (2000: 498) points out that the challenges for health policy makers are "how to make clinical autonomy responsible autonomy," and this requires an acceptance of the need for change.

Several respondents recognised environmental changes and the necessity for changes in the medical profession - a contingency approach. Clearly the medical malpractices cases have caused some of the respondents to recognise the limitations of self-regulation and the need for change as in, "It's something we're just going to put up with because we are just really bad at regulating people" *(Consultant 010)*. There was seen to be an acceptance of greater public accountability "if it is done in the right spirit" *(Rheumatology 007)*, but some considered it has been "taken too far" *(Paediatrics Specialist 010)*. It was also found that appraisal was accepted in principle and if done correctly "it can impact patient care, but most importantly it can impact on doctors themselves" *(Consultant 001)*.

One example of the shift from personal to collective responsibility - from professional to responsible autonomy - is provided in the following narrative:

> *"As he was chatting, this colleague of mine said, "Oh my god, we have surgeons here and this is just beginning to ring a few bells." Now this surgeon I'm pleased to say has moved on to an academic post elsewhere, so we don't have to worry about it. But one of the things he said "[Name], do you remember I came to you and I said we have concerns. The [outcome of] cases he was doing on the ICU was not as good as similar cases done by another surgeon.' But the person about whom we have concerns was the audit person for surgery. In fact I said, "Now you've told me this, I don't have any option. I have to tell the medical director." And I think a lot of things went on behind closed doors and there was certainly the sensation of him not doing that sort of procedure until we'd looked at the figures." (Consultant Anaesthetist, 078)*

Here we can see a subtle change from what 'went on behind closed doors' to an acceptance of collective responsibility shown by the need to report the identified poor performance. In earlier days this may have gone unreported, as in "I think in the past most people kept their mouth shut when there have been problems" *(Associate Specialist 004)*.

Nonetheless the data provided some evidence that doctors feared the loss of professional autonomy and that the desire to control the labour process of the medical profession may "concentrate blame and conflict" (Klein & Maynard, 1998: 1). This was exemplified by one consultant who argued that external evaluation of performance may create an atmosphere "where people will give up their professionalism to fit the management's way of doing things" *(Consultant 022)*. Responsible autonomy implies taking responsibility for the performance of colleagues and this was said to have led to the medical profession becoming more defensive. However other factors may have increased defensiveness and one might be increased litigation, as in "My concern is that when I get sued, as I'm sure I will, the patient say, "Why did you do that?" *(Consultant 014)*. Responsible autonomy also suggests a reduction in personal responsibility and several senior doctors recognised that attitudes have changed with junior doctors having less commitment to patients and, "They are much less

motivated. They consider it is 'just a job' not a vocation to them. They don't care about the patients like us older clinicians do" *(Ophthalmology Associate Specialist 005).*

A paradox was found between targets and accountability. Responsible autonomy was said by Goddard & Mannion (2006: 73) to weaken incentives where "a high degree of autonomy is enjoyed regardless of measured performance against central targets." Informants rarely agreed with targets, as in "'Performance by results' is ridiculous. [The government] will reward the large Trusts with more staff and not those trying to improve" *(Anaesthetics Specialist 009).* Appraisal itself was seen by one as yet another target to demonstrate that a Trust can obtain a star rating *(Staff Grade 0573).* The emphasis on targets was seen by one consultant to trump patient safety.

It can be concluded that the responsible and professional autonomy discourse has been well identified in the data and that the concepts interact with the data well. It seems that responsible autonomy is unlikely, from the limited evidence, to replace professional autonomy. However, there were some positive observations on responsibility such as, "I know that in other industries [appraisal] is part of the culture change, and in the NHS it makes people more responsible for their actions" *(Consultant 01).* But doctors have an "attachment to the strong sense of elite occupational and professional social identity" and are therefore "reluctant to surrender their PA to close managerial scrutiny and state control" (Worthington, 2004: 65). Thus tensions are likely to remain and it is unclear from the data the extent to which either mode of autonomy creates the greater threat to patient safety. Opinions seem divided amongst the doctors on this issue.

(Post-) bureaucracy and mock bureaucracy

The data well support the concepts around mock bureaucracy and its restraining effects on (post-) bureaucracy. Mock bureaucracy implies covert organizational non-compliance and whilst rules and procedures are in place they are not enforced because doctors and managers believe "they do not hold any legitimacy for either group" (Gouldner, 1954: 185). With the tightening of bureaucratic control, conflict between managers and doctors increased as the locus of control seemed to shift towards the top. For example, "'Us and them' is increasing between clinicians and managers" *(Anaesthetics Specialist 009).* The reduction in the power of doctors was also recognised: "Under the regulations we become less and less powerful to make decisions and therefore [appraisal] has an impact on doctors" *(Doctor 211).*

Much of the evidence indicates that mock bureaucracy and its tactics may provide the methods of doctors' resistance, mostly passive, to the loss of professional autonomy. Such

comments as these indicate that such exercises are met with cynicism and doctors seem resilient to the processes and reinforce passive resistance:

> *"The process is a meaningless paper exercise."*
> *"Only a very brief 15 minutes paper exercise."*
> *"Just a paper exercise. A formality really. It is a total waste of time."*
> *"A leg pulling session."*
> *"It was just a formality, completed in five minutes."*
> *"Like rubber stamping."*
> *"A routine procedure. Not very person-specific. Fairly superficial."*
> *"Just a ritual."*
> *"The rigmarole of it."*

"To me they [appraisals] are just a paper exercise...we have got bits of paper to say I have been appraised, I have been revalidated. But nobody really knows what I am doing or how good I am. I could just be good at filling in papers" *(Associate Specialist 003).*

Where rules are seen to have little intrinsic value and their violation seem to have few adverse results, they were by-passed or subverted "by multiple organizational sub-cultures" (Jermier, *et al.,* 1991: 607) of doctors, often with the tacit collusion of managers, who were eager to avoid direct conflict. One consultant had compared A & E practice in the US with that in the UK and noted that some patients had been on trolleys for up to 18 hours waiting in the department in the US because targets there were geared to elective surgeries, which were never cancelled, and emergencies had to be fitted around that. She goes on:

> *"Now I actually think that is a good idea to say that you must not have trolley waits longer than a certain time. But we have worked ourselves to frenzy. We have put artificially vast numbers of extra people down for a week in A&E, just so we can tick that box."*
>
> *"People have said, 'That's immoral,' but I said 'If we can't tick that box, the Trust will be starved of more money, and nothing the Trust will do will make them give it. So, which do you want to do, just swallow it and go down that road, or not?'*
>
> *"I have a very high opinion of our Chief Executive. I think he's a great Chief Executive who works very hard, and he'll say, 'I know exactly what you mean. It's immoral, but this is forced upon us by the Department of Health.'"*
>
> (Consultant Anaesthetist 078)

This is a clear example of mock bureaucracy at work in a hospital, with references to ticking boxes and subverting rules, and also indicates the management response at the highest level in colluding with the practice.

Responsible autonomy, especially as manifest in appraisal, was seen by scholars (Maravelias, 2003; Grey, 2002; Budd, 2007) as a move towards post-bureaucracy, with its features of decentralisation, consensus and porous boundaries. There is the tension between

empowerment and a mere extension of control by different means. Maravelias (2003: 547) from a critical management viewpoint sees it as "a totalitarian regime" subjugating individuals to the instrumental needs of the organization. He argued that presenting post-bureaucracy as being "an emancipator regime" was actually "a way of masking its more fundamental discourses of instrumental efficiency and control" (op. cit.: 550). Responsible autonomy seems to imply that "the profession as a whole is responsible for ensuring the accountability of individual doctors - the self has been reinterpreted as the profession acting collectively to assure the quality of all doctors" (Rosen & Dewar, 2004: 44).

The data provide examples of these features of responsible autonomy. A paediatrician argued that appraisal was being used inappropriately (not developmentally for individual benefit) rather, "It is being used to target individuals with negative criticism with no positive impact on patient care - may even be negative" *(Paediatrics Specialist 010).* The recent initiatives were seen to be "very much service oriented - not much place for career improvement" *(Staff Grade 1121)* and "The organisation's drive is to meet Government service targets" *(Consultant Orthopaedic Surgeon 236).*

The following narrative indicates the apparent shift from an emphasis on individual consultants to the hospital as an entity:

> *"My impression is that management has developed a service like where patients come to [City], not because of the [Hospital Name], especially to see me. I don't mean to sound big headed. I wouldn't be who I am without the team, but I've got certain information, which has let me to the conclusion, that the hospital resents having patients come to specifically see a consultant, that the consultant has the power of possessing patients. And what the hospital wants is for the patients to come to the hospital and then it doesn't matter who they see."*
>
> *(Consultant 02)*

In this scenario, post-bureaucracy with its tendency to reduce the significance of personal identity, "leaves individuals with no other choice than to bring their personal and social registers into play" (Maravelias, 2003: 561). This attempt at the subsuming of the individual, as indicated by Consultant 02, is also identified by Coates (2004) in his study of NHS appraisal (for women only). He found that appraisal records were being (mis)used as a control means to impress on individuals "that their identity either reflected or refuted" that of the trust (op. cit.: 584) and that the purpose of appraisal as a performance measure was being replaced "with rhetoric" and the adoption of the trust's identity (ibid.).

However, against the evidence of mock bureaucracy (paying lip service) should be offset the effectiveness of the control system as indicated in this comment: "People have very

much paid lip service to appraisals, particularly for junior doctors but recently, regionally, we've failed a couple of people on their annual appraisal, and it's given them a kick in the pants" *(A & E Doctor 065).*

It seems that the data confirms the presence of mock bureaucracies in NHS hospitals and indeed the presence of clan cultures within a hospital bureaucracy indicates its potency. Mock bureaucracy seems from this data to be the principal means that doctors may use to resolve the tensions between professional autonomy and the post-bureaucratic mechanisms instituted by the Labour government to reduce medical power and increase centralized control over clinical practice, though the mechanism of appraisal linked to revalidation. Thus the data seems to support the conclusion of Goddard & Mannion (2006: 67) that, "The tension created by such opposing forces has an impact not only on inter-organisational partnership working but also on the balance of power within local health economies."

Panoptic surveillance versus the power of medical knowledge

Panoptic surveillance may be seen as a means of overcoming medical secrecy through internalisation. The government specifically uses the term 'surveillance' as in the identified need for "strong surveillance mechanisms to detect problems at an early stage and log incidents" (DoH, 2007b: Para: 5.2). "Appraisal operates as a form of panopticon with its anonymous and continuous surveillance as seen in the articulation of a monitoring role" (Townley, 1993: 232). She argues that appraisal is a mode of surveillance, which "turns employees into self-disciplinary subjects of managerial control, from which she claims there is no possible means of escape or possibility of resistance" (Worthington, *et al.*, 2006:2).

The data do not accord with this concept that panoptic surveillance may overcome medical secrecy and the power of medical knowledge, because the "tacit nature of medical knowledge and competence" serves, intentionally or not "to enable doctors to preserve key elements of traditional medical professional power and identity" (McDonald, *et al.*, 2006: 183). Nor does this study agree with Coates' (2004: 568) contention that, "As appraisal is a form of knowledge over individuals through their appraisal files, it also constitutes power over them." Since most doctors, from my data, know how to manipulate their files, this power is not as significant as this author suggests.

Resistance has been demonstrated in the previous section to be possible through techniques of mock bureaucracy, which shows passive resistance by resorting to tactics of 'anticipatory conformity,' 'appearance management' (Zuboff, 1988) or 'resigned behavioural compliance' (Thomson & McHugh, 2005). For example, "If there really was a problem

with my work, it probably could easily be disguised during appraisal" *(Senior Clinical Medical Officer 0162)*. Defensive self-protection is encouraged by surveillance, as the following comment indicates: "It's all about 'Watch out, for you might be doing wrong!' *(Associate Specialist Dermatologist 003).*

In addition, the current appraisal processes designed for use in the NHS allows all the documents to be organised by those being appraised. As presently constituted, appraisal "depends ultimately on the honesty of the appraisee" *(Consultant Anaesthetics 040).* Therefore this leaves considerable room for doctors to manipulate the data of their portfolio should they wish to resist. "I suppose you might say cynically, 'Don't mention anything in your personal development plan, if you're not prepared to go out and do it.'" *(Consultant Anaesthetist 078).*

The use of patient feedback and relationships with colleagues are two components of the portfolio that are open to manipulation. Indeed, one consultant admitted that, "Relationships with colleagues, patients etc are impossible to objectively assess other than through complaints" *(Consultant 124).* Even where data is not deliberately being manipulated, there may be the suspicion that it is, as the following narrative demonstrates:

> *"I am all for external scrutiny. They suggested that we give our patients satisfaction questionnaire. And now the patients can fill them in. But the problems is that the questionnaires come to us, so when I sent them to the hospital, there was a remark that the results were incredibly good. That suggested to me that there was some kind of insinuation. That we were being selective in the questionnaires we send to them. I felt there was some ambiguity so I tried to arrange for an external assessment to check this, but I haven't found anyone from outside to do it."* *(Consultant 02)*

It is difficult to assess, without further evidence, the extent to which the lack of relevant, reliable and objective data is a genuine concern or an excuse to omit objective evidence in the portfolio as a means of denying management the necessary information for surveillance purposes. A study on the use of hospital episode statistics to support appraisal (Croft, *et al.*, 2007) suggests that the problem with such data is the lack of access to central hospital data and the lack of professional support to interpret it. Certainly, informants have complained about data access as in, "There is little access to certain statistical data regarding patients seen just by me" *(Senior Medical Officer 0693)* or "The Trust has no formal feedback forms from patients and colleagues" *(Staff Grade Psychiatrist 0813).* There might be a suspicion that this could be a convenient excuse not to present it.

In Foucauldian terms, surveillance has two separate activities, one is the collection of information and the other is supervision and regulation of behaviour. These two activities

are mutually reinforcing and supposedly produce disciplinary power so that, "the very collection of information normally presupposes a certain capacity to supervise and manage behaviour and vice verse" (Dankeker, 1990: 39). This is exemplified by the appraisal process, as indicated above. First, the appraisal process requires the doctors to collect the information on their day-to-day medical activities, such as feedback from patients, and working with colleagues. That information is then organised into a profile folder to reflect the professional performance used in appraisal. However the relevance of patient feed back was questioned by one consultant who argued, "You can have a guy who is really a bit brusque, who isn't perhaps the best at creating great working relationships with the patients, but is fantastic at doing his job" *(Consultant Anaesthetist 078).*

The second activity is the supervision and regulation of behaviour, as Ouchi & Maguire (1975) term it 'behaviour control,' based on personal surveillance and manifest in the proposed linkage of appraisal to revalidation and the licence to practice. Thus, the collection of information regarding professionals' activities generates the capacity, as well as the power, to create more self-discipline around medical professional behaviour. Hence, the appraisal process presents a new form of control tool imposed on the doctors. In other words, the current appraisal process is about governance of 'regulating at a distance' or 'auditing of all kinds' whereby the action of 'audit' implies both control and regulation (Flynn, 2002).

From the data in this study we can see these activities clearly at work. The evidence is not decisive around the actual effectiveness of these forms of surveillance but there is sample evidence that doctors are proficient in the game-playing and tick-box mentality that might suggest that resistance to the control tool of appraisal is possible and seems to be happening with some of the survey respondents and interviewees. Indeed, even Townley (1999) subsequently modified her views on surveillance, finding that its effectiveness at practice level was reduced by the power of professional judgment pitted against the rational nature of performance guidelines.

However, there is contrary evidence which suggests that some doctors are conscientious at collecting data by completing a log book to allow personal reflection. For example:

> *"When you get the actual figures out...you are amazed at what you did...or how many went straight to intensive care, so it does make you very reflective on your own performance."* *(Consultant Anaesthetist 078)*

Again another consultant suggested the personal benefits of collecting objective data:

It does make you think a lot. When you are looking the figures and what you do, we tend to over-estimate how much we do. We tend to over-estimate how good we are. We really do. We see patients, we operated, and they get over the operation and then we seen them six weeks later. And you don't know what happened between those times. We give them a questionnaire to ask them what has happened, [and] how many times they saw [their] GP, and what amazed me is how poorly these patients are once they are home." (Consultant 14)

It would seem that those doctors who find evidence of positive personal outcomes from the collection of and reflection on the data they have assembled, and then there is likelihood that they may not subvert the process through game-playing and manipulation. What is not clear from these two interviews is the extent to which the system has used this information for surveillance purposes. However, when the data which has been collected personally, it is impossible to assess its validity at least without a third-party verification.

This section has assessed the interactions between the data from this research and the theories and concepts that seem pertinent to the study. It was found that Ouchi's theory needs extending to take account of the greater complexity of control mechanisms in the NHS since he was writing. Whilst it was found that the concepts around professional and responsible autonomy were informative, the data was insufficiently extensive to adjudicate between the relative potency of each of these modes of control. The interactions between (post-) bureaucracy and mock bureaucracy and the data were sufficient to support the concepts and mock bureaucracy was seen to be common-place as a means of protecting their professional autonomy and individuality. Panoptic surveillance was found from the evidence not to be as effective as a means of control as many authors suggest, indicating that the concept is somewhat limited here. This indicates that appraisal as a form of control is perhaps necessary but not sufficient to achieve its aim of controlling the clinical performance of doctors.

6.3 Relating this study to similar studies

Before answering the main research question, it is wise to review similar research on the subject of medical power struggles, on control mechanisms and on appraisal in the NHS. Partly this is because of the limitations of the data and its unrepresentative nature and partly because interpretation of what is essentially subjective opinions and narratives of the informants is easily open to biased interpretation. By reviewing similar studies, it may be possible to evaluate different and indeed similar interpretations of broadly similar data.

It is somewhat surprising that there appears to be so few studies on the appraisal of HNS hospital doctors, but there has been more work done systematically on the appraisal of GPs (see for example, Lewis *et al.*, 2003; McKinstry *et al.*, 2005; Boylan *et al.*, 2005; Cornish, 2006; Colthart *et al.,* 2007). Comparability with this study is somewhat problematic since GPs are independent contractors rather than direct employees of the NHS. One issue that was regularly raised in these studies by GPs was that of personal health, but this was not mentioned by informants in this research. However, the uncertainty over the relationship between appraisal and revalidation and the tensions between the formative and summative functions of appraisal were a feature both of the GP studies and this study. Similar to this study, the developmental nature of appraisal was generally welcomed.

Similar to this study, the GP studies found evidence of "strategic form filling rather than honest analysis" (Boylan, *et al.*, 2005: 545), being economical with the truth, or that "it encourages gaming and evasion" externally and "collusion" internally (McKinstry, *et al.*, 2005: 542). Again similar to this study, the nature of the portfolio evidence was questioned on its objectivity and on the availability of corroborative materials. Again similar to the findings in this research, clearer guidance was wanted, more time was needed and greater support required to support the paperwork demanded. Finally, the issue of the effectiveness of appraisal in having positive outcomes on personal performance tended to be higher amongst GPs than amongst the hospital doctors in this study, especially when GP appraisal was "a formative process conducted by trustworthy peers" (Lewis *et al.,* 2003: 459).

One study is of particular relevance since it seems to be one of very few which relates appraisal to improvements in clinical outcomes. West, *et al.* (2002) set out to show a link between HRM practices in NHS acute hospitals and hospital performance, as represented by the impact on patient mortality. They found positive associations with performance levels of appraisal, training and team working on patient outcome. They concluded that, "appraisal has the strongest relationship with patient mortality, despite the small sample size" (op. cit.: 1305), but their detailed case studies also found that team working was a significant factor in improved clinical performance. However, the authors admit that performance data for NHS hospitals "are unreliable and incomplete" (op. cit.: 1308).

The data in this thesis do not support the conclusion that appraisal has a direct positive effect on hospital performance, though impacts on personal performance were more often commented upon. Doctors generally were unable or unwilling to identify effects on hospital performance:

Question: "Was it [appraisal] in any way helpful for the organisation?"

Answer: "I don't know." *(Consultant 02)*

Question: "Do you think that the appraisal process is in any way developmental for the organisation?"
Answer: "No. I don't think so. It is just to do it better but like a duty. But it is a good idea if we can start the process somewhere."
Question: "Do you think appraisal helps sharing best practice?
Answer: "No, I don't think so. It's too discrete." *(Doctor 211)*

However, some potential for impacting overall hospital performance was identified, especially in the sharing of best practice but appraisal was not seen as, "not necessarily the best, or the most appropriate, but it is an opportunity" *(A & E Doctor 065).* This informant cited the complaints procedure as being more effective in identifying poor clinical performance. A consultant believed that appraisal's function "in other industries is a part of culture change, and in the NHS it makes people more responsible for their actions" *(Consultant 003).* This study only concentrated on individual doctors' perspectives on appraisal and did not review overall hospital statistics nor was it a longitudinal study, in which impacts over time may be assessed.

In addition to West *et al.* (2002), team working was also identified in a study of consultant paediatricians' views on appraisal, in relation to outcomes of care and the process of care (two key appraisal criteria). Davies *et al.* (2005: 167) found that care outcomes, "more usually reflect team performance than that of an individual" and that although the process of care was more directly under an individual's control nevertheless "behaviour of the rest of the team will still have some effect" (ibid.). Similarly, Shaw *et al.* (2007b: 175) concluded that "most of medical care is administered by teams and the quality of care is intrinsically linked to the infrastructure and support available in delivering the service." In the interview data in this thesis, team working was identified as significant in accident and emergency and in surgery, but was not identified as a limitation of appraisal as a control mechanism by the majority of informants, who tended to focus on their individual concerns.

Team working was found to be a better way of improving clinical performance in some cases:

"Within A & E where we work very closely with each other, it is important that there is a place where people can express their opinions that things are going wrong."
"It's an opportunity to talk about people's performance and people's perception of their own performance as well, because people may think they are doing fine and actually they are not." *(A & E Doctor 065)*

"If you want to know what surgeon to go and visit for a particular type of operation, ask the anaesthetist and they'll give you an honest answer. And it works the other way round." *(Consultant Anaesthetist 078)*

These comments, whilst not typical, would suggest that appraisal as presently implemented on an entirely individual basis can fail to capture the effects of team working and suggests that peer reviews and peer rating may need to be incorporated more formally into the appraisal propcess. This accors with Chamberlain's (2010: 7) observation that poor performance would be "detected by clinical colleagues at the day to day level..not in an apraisal meeting."

In Redman *et al.*'s (2000) study of appraisal in an NHS hospital it has to be assumed that this was for non-medical staff (though this is not directly stated). Their conclusions were similar to those in this thesis in that implementation was found be be patchy and this was attributed to the professional and politicised nature of the NHS and, as in this study, also attributed to inconsistent management commitment to the process. Their key finding is that, "Traditional bureaucratic controls of direct monitoring are both costly to implement and also undermine employee discretion" (op. cit.: 60) to which my study would add the undermining of morale and professionalism. Unlike my conclusion, these authors believe that appraisal problems can be "ironed out over time" (op. cit.: 61).

Two research studies on appraisal (McGivern & Fairlie, 2007; Chamberlain, 2010) relate directly to this thesis, and come to some similar but also some different conclusions. Chamberlain interviewed 46 NHS appraisers of medical students and junior doctors from one location, whilst this study involved interviews with 52 from a wider area. Additionally, the data in this thesis were supported by 1849 questionnaire surveys from four regions of England and this provided some degree of triangulation with the interviews and more potential for generalisability. Chamberlain grounds his research in Foucauldian concepts of the information panopticon and, similar to McGovern & Fairlie, relies on Power's (1996) emphasis on contemporary trends in audit. This thesis differs in that it explores more dimesions, such a Ouchi's clan and bureaucracy, tensions between professional and rssponsible autonomy and the restraints on (post-) bureaucracy through mock bureaucracy.

Chamberlain's conclusions around the context of appraisal in respect of time, training and follow-up are confirmed in this thesis, but are more nuanced here. Generally, the disparities between different grades was emphasised, with very patchy implementation for staff grades and such comments as, "As usual Associate Specialists receive better treatment than Staff Grade and Trust Grade." (*Associate Specialist 1293*). For example, in time allowed for

preparation for appraisal only 55.4% of Non-Consultants were satisfied, compared to 76% of Consultants. Similarly only 47.6% of Non-Consultants received training compared to 63.6% of Consultants. However, both grades bemoaned the lack of follow-up, especially the resources that could be allocated to it. The most relevant point is that writing in 2010 Chamberlain still finds these problems with appraisal which might suggest they are not, as Redman *et al.* (2000) suggest, teething problems that would diappear over time but more fundamental issues with the process of appraisal.

The data in this thesis generally confirm his main conclusion that appraisal as a Foucauldian "punitive disciplinary tool" (Chamberlain, 2010: 3) is being subverted by what he calls 'paperwork compliance,' which he claims is a conceptual tool and a heuristic device helping the analysis of appraisals in other contexts. Chamberlain refers to creative game-playing, the ritual nature of ticking boxes and the superficial role of standards. The findings in this thesis converge with the view that his conclusion "reinforces the limitations of the Foucauldian perspective" (op. cit.: 11).

However, my findings go further in respect of the tacit nature of doctors' specialised expertise and suggest that the role of standards, which Chamberlain downplays, is more significant. And what is at fault is the finding that the standards, as laid down by the GMC, fail to capture the complexity of clinical practice because the standards are too broad and need greater focus on medical specialities that only the Royal Colleges can supply. Chamberlain also focuses more on the summative rather than the formative function of appraisal and my findings indicate more positive perspectives on the potential developmental nature of appraisal, as the following narrative indicates:

> *Question: "What did you expect to get out of being appraised?"*
>
> *Answer: "I was hoping to get a useful perspective about my career from somebody who would be unbiased and who would discuss with feelings, my ambitions and frustrations with me and how things may be improved and make suggestions as to how things might be improved."*
>
> *"Once I had my experience it was a negative experience. Now it is just a ritual, but I wonder whether I should take steps to make it a useful process."*
>
> (Consultant 02)

McGivern & Fairlie (2007) come to broadly similar conclusions as this thesis, and as Chamberlain does, around the ritualistic approach by doctors towards appraisal in its summative mode. They argue that, "most consultants played tick-box games to create the impression of accountability, while continuing to practise in a traditional way" (op.cit.:

1380). These authors limited their data to two HNS hospitals and to consultant grades, unlike this research which included Non-Consultants and Staff and Associate Specialists from more hospitals. They similarly interviewed 54 consultants but in addition interviewed hospital managers, BMA and GMC which regretably is absent from this thesis, but these authors did not have the benefit of nearly 2000 questionnaires surveys which were used here.

McGivern & Ferlie provide four perspectives on appraisal. The first is developmental whose rhetoric, they argue, masks government desires for more explicit and controllable accountability, and data in this thesis support this contention. The second is Foucauldian control in which tacit professional norms and practice-based judgment is able to trump the bureaucratic rationality of objective protocols designed to meet government targets, and again the findings in this thesis support their conclusion. The third is ritualistic supplying of evidence for use externally which presents "an artificial and static reality upon changing and unstable forces" (McGivern & Ferlie, 2007: 1367) for public consumption and political purposes.

The tick box mentality and rigmorole were identified in the data in this thesis and related here to mock bureaucracy, but the implicit causes for this were more varied than these authors suggest. Interview data indicated the genuine difficulties of sourcing relevant data and the impression gained was that the performance measures were too general to be appropriate to many medical specialities. It would seem that the instrument was too blunt to be of perceived legitimacy to many of the informants and the ticking of boxes was not just for the purposes of resistance to the process but also a reflection on the lack of sophistication of the performance measures to be reported upon, as many were considered "routinized recording of trivilities" (Barlow, 1989: 514).

Their fourth perspective, that of social, bureaucratic and ritualistic defences against anxieties, forms the basis of their principal research findings. Limited evidence was found in this thesis around anxiety, one example being, "a climate of a lot of anxiety amongst medical staff about the attitude of the government to them" *(Manager 01).* Whilst several participants in this thesis found their performance evaluation to be disconcerting and "is a threatening experience" for both parties (Duncan, 1978: 336), it was found to be threatening only when it was negative feedback or was done by individuals perceived to be unqualified, or where there was disagreement over who sees the evaluation.

McGivern & Ferlie use a theoretical framework based on psychodynamics (for example: Klein, 1946), whereas the framework in this thesis is multifaceted and based around theories of control. This was because no participant observation was possible and this seems a necessary type of data for valid conclusions on behavioural dynamics and also because control theories have been cited by numerous scholars as having explanatory power when tracing the struggle for control between the State and the medical profession over three decades of NHS reforms. This thesis is more about control mechanisms and appraisal is used as an exemplar of one control mechanism and its tensions when set against professional autonomy and the medical clan cultures.

Both Chamberlain and McGivern & Ferlie develop typologies. The former around non-compliers, minimalists and enthusiasts but all informants reported that the doctors' folders played "a highly superficial role" (Chamberlain, 2010: 6) in appraisal process. The latter classified consultant responses to appraisal under the labels of development, disappointed reflection, defensive assessment and a waste of time. Whilst the data supports all these categories, this thesis is unable to develop a typology because the reponses here are more diverse and cross many of the boundaries created by these authors. The reason for this may be that the data set for this study is wider geographically and numerically (especially when answers to open questions in the survey are included) and importantly encompasess many more hospitals, which may have entirely different organisational cultures.

The section has reviewed research that is similar in nature, in data or in style to this thesis in order to locate this study in the relevant reaserch landscape. It was found that whilst the data here accords with many of the findings in the work of other scholars, there were significant differences in approach. The study has built upon the work of these researchers and developed new concepts related to the struggle for control of the clinical performance of doctors in the historical context of decades' of NHS reforms.

6.4 The extent to which government can control clinical performance by appraisal

This section seeks to answer the main research question about the extent to which the government is able to control the clinical performance of doctors in NHS hospitals through appraisal. The key finding is that the appraisal instrument currently in force is not necessarily a predictive model for change in the NHS, despite the finding that some changes have been effected. There is a danger of attaching too much significance to the changes that could be brought about by appraisal leading to revalidation. Informants conveyed the

message that if current appraisal practice was deficient for evaluating doctors' performance, and lacking credibility, then appraisal as a tool to control medical performance was less likely to achieve its aim to improve healthcare delivery. But it was further suggested that appraisal linked to revalidation "may increase apparent accountability, but may not foster a culture which increases patients' trust and doctors' professionalism" (van Zwanenbery, 2004: 686) and the data accords with this view. The reasons for appraisal's apparent failure to control the clinical performance of doctors is now examined.

It was seen from the data and the literature that appraisal serves three functions - performance measurement, impact assessment and developmental learning. First, and most importantly for answering the main research question, appraisal is based on the measurement of performance for accountability, transparency and efficiency. However, the issue is for whom and for what is the accountability. From the data and that part of the literature review which traced the development of NHS policy reforms, it seems that accountability is upwards to the politicians represented by the Department of Health, downwards to individual patients, but also horizontally to peers and colleagues to preserve the institutional norms and vales of the medical profession. It is multiple and collective accountability. However, "equal accountability to all at all times is impossible" (Edwards & Hulme, 1995: 10), and this creates inevitable tensions.

The concerns, often alluded to by the informants, are that, "Performance is a multi-faceted, fluid, problematic, ambiguous and contested concept" (Paton, 2003: 5). Good performance is not an attribute but a social construct and it does not lend itself to scientific evaluation, since "surgical power is not something which is just a given, but it is something achieved by a social process" (Fox, 1992: 131). The portfolios presented by doctors for appraisal is supposedly evidence-based to permit evaluation by showing objectively verifiable indicators which should have a means of verification. Evaluation of performance has long been a common practice in the management of development and acceptable indicators should be specific, measurable, agreed, realistic and timely (Coleman, 1987).

The indicators for appraisal seem not to be sufficiently specific, especially the GMC guidelines for good medical practice for specialisms, for example it is "extremely difficult to obtain objective evidence of anaesthetics" *(Consultant Anaesthetist 040)*. The second feature of an indicator is that is should be measurable, but such a scientific approach may skew appraisal towards what is measurable. Indeed quantifiable measures are not the only important ones, as illustrated below:

"So the fact that I did only one case on Monday morning that lasted five hours and I might only do three cases this week even though its probably taken 16-18 hours to do. So it doesn't mean anything that I've done three big cases compared to 13 small cases." *(Consultant 015)*

Hart (1997: 266) argued that "over-concern with purely quantitative indicators of quality could lead to the emergence of practices, which actually destroy quality" and managers are too rigidly focused on setting and meeting targets which become increasingly less responsive to changes in the environment. Even finding quantifiable indicators in some disciplines is problematic, as the following observation shows:

"The main problem we have within A & E is how do you appraise somebody in A & E? I don't know. I don't have an operating list, I don't have a bed list. So it's impossible to say how I'm performing and how the department is performing. It's difficult to quantitatively appraise my performance. But, in some ways qualitatively [it can be done]." *(A & E Doctor 065)*

The third feature of an effective indicator is that it is agreed. It would seem from the data that appraisal was introduced with insufficient consultation over the measures to be used to assess clinical performance, certainly at the local level. Peer reviews are likely to produce more realistic measures, for example, "If you want to know what surgeon to go and visit for a particular type of operation, ask the anaesthetist and they'll give you an honest answer, and it works the other way round" *(Consultant Anaethestist 078).* It seems that indicators negotiated between peers would probably lead to greater realism and acceptability, and counter such comments as, "I would cancel several clinics rather than waste my own time on this" *(Consultant Dermatologist 306).*

The fourth feature of a performance indicator is that it is realistic, both in terms of its relevance and in terms of its consumption of clinical time. The challenge of making measures of performance realistic emerges from Ouchi's (1979: 837) observation that in the medical profession, "task performance is inherently ambiguous, and team work is common, so that precise evaluation of individual contribution is all but impossible." The perceived right of doctors to be, "the arbiters of their own work performance, justified by the claim that they are the only ones who know enough to be able to evaluate it properly, and they are also actively committed to ensuring that performance lives up to basic standards" (Freidson, 1974 : 33). From limited interview data it seems that through the *New Ways of Working* initiative there is a degree of making indicators realistic and explicit:

"And then the last theme I have is protocol-based care, which is trying to be more explicit about the stages of treatment a patient goes through and who does what, and

it's very relevant to having to change people's roles, so there are guidelines and descriptions of what people do." *(Manager 117)*

From the above discussion it would seem that, "Appraisal is a rather blunt tool with which to judge effort and value" (Coates, 2004: 569). In its present form it is too much a quasi-scientific instrument rather than a context-sensitive process, which engages with all participants in it on an equitable and negotiated basis.

Appraisal may also be seen as a form of impact assessment on outcomes, patient safety and effectiveness of healthcare delivery. Appraisal seems to have been introduced with some haste following the publication of the Shipman inquiry reports, at least circumstantially. It is "a sledgehammer to crack a nut" *(Consultant 003).* Firth-Cozens (2001: 114) argues that any type of management control which "make doctors unhappy may adversely affect both the quality of care and patients' satisfaction"

One serious issue is attribution - that is whether improved patient safety can be explained by the performance of an individual doctor. The appraisal process may be too rigid in its cause and effect assumptions. Patient safety is likely to be affected by a range of factors, including team working, resource allocation, workload, hospital cleanliness or quality of communications. For example, "If people's appraisals have all gone well and then there's a major clinical incident then something's gone wrong with the appraisal" *(Consultant 015), but* the adverse event may be attributable to other factors.

As a means of rooting out poor performance, the evidence here and in similar studies has indicated fairly conclusively that doctors do not believe appraisal alone is sufficient to achieve this objective. "Everybody trots out that [appraisal] wouldn't have prevented Dr. Shipman" *(Consultant Anaesthetist 078).* Partly, this is because the instrument is too blunt and rogue doctors are probably capable of giving a good appraisal. Partly, it is because a growing blame culture in the NHS encourages poor surgeons to "feel obliged to cover [poor performance] up" (Evans *et al.*, 2005: 769) and the evidence here suggests that poor performance is, and should be, dealt with outside the formal appraisal process. The link to revalidation is creating caution such that it which will "encourage people to cover up errors for fear of retribution and act against the identification of the true causes" (Donaldson *et al*, 2000: ix).

As a means of effecting organisational change, many informants did not, or could not comment positively. For example, "The appraisal process has not had any significant impact on the problems facing the Trust" *(Staff Anaesthetist 0984)* and many interviewees,

when asked directly, offered no comments. Whilst organisational benefits were not confirmed by the evidence, individual benefits were attributable to the appraisal process.

Thirdly, appraisal is also seen as a facilitator of learning in a developmental and formative role. Evidence from this study and from similar studies indicated that many doctors found that appraisal facilitated reflections on their practice. The potential for appraisal as a formative process was seldom doubted. However, this was diminished by patchy and inequitable implementation and the failure to follow up and provide developmental resources to meet the doctors' agreed needs. Nonetheless, the response to appraisal was positive but its potency was seen by many to be diminished by its linkage to a performance assessment function and further as a means of revalidation. Performance appraisal should aim to assist those being appraised "to develop in their role and should not be conducted on a 'pass or fail' basis" (MDU, 2005: 3).

Appraisal should not be an entirely top-down process since, "changes which do not take into account the concerns and motivations of lower level staff do not generally produce long-standing change" (Beer, *et al.*, 1990, cited in Davies & Mannion, 1999: 11). Pringle (2006: 162) thought that the process of appraisal should be a peer review, in an open and honest manner to discuss strengths and weaknesses in terns of shared learning for the future. It should be "a formative, not summative, process." If these two functions of appraisal are not decoupled, then the danger is that "the developmental benefits of appraisal will be lost, and the present 'blame culture' will endure" (Myerson, 2001: 200).

The failure of appraisal to deliver the objectives of realistic measurement of performance and positive impacts on patient safety, despite its perceived potential effectiveness as a means of development for doctors, suggests that it should be integrated within a new governance structure. The next section works towards a new framework, since "performance appraisal's critics are usually silent on what should replace it" (Redman *et al.*, 2000: 60).

6.5 Putting the jigsaw together - towards a framework of the control of doctors

This section, through a governance lens, brings together firstly the areas where the data do not fit easily with some of the theories and concepts, secondly the findings of this thesis related to somewhat different findings in similar studies and, thirdly, the relative ineffectiveness of appraisal linked to revalidation to control the clinical performance of doctors. These three strands when juxtaposed suggest that a new configuration is demanded

which is context-sensitive, accommodates the limitations of current control theories and considers appraisal less as an control instrument and more as a component of a wider governance system.

It is the contention of Kuhlmann & Allsop (2008: 184) that, "barriers to governing medical performance are embedded in policy frameworks and are not simply an outcome of the self-regulatory powers of doctors," which some theories and some conclusions of similar studies would suggest. Similarly, Davies & Mannion (1999) and Newton & Findley (1996) both argue that organisational structures and contexts in which appraisal is conducted have to be considered. Therefore, the development of a modified national architecture of governance within institutional frameworks, sensitive to a changed and changing environment, seems to emerge from the data in this thesis. In this way, professional autonomy and responsible autonomy may be reconciled within a wider governance configuration. This moves the discourse towards structure and away from agency.

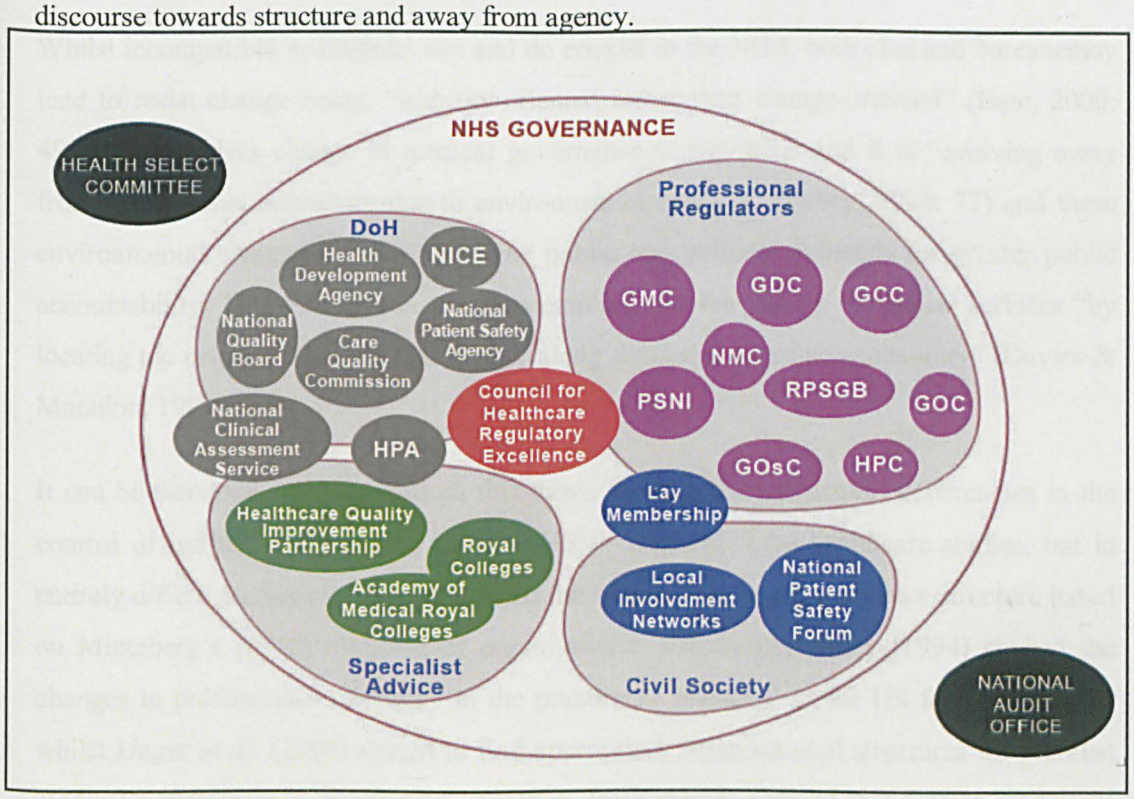

Fig. 6.1 Current NHS Governance Systems Map

The existing structure for medical and clinical governance is cumbersome, complicated, includes considerable duplication (van Wanenbery, 2004: 686), and has changed even during the course of writing up this thesis (Fig. 6.1). Appraisal encompasses the involvement of bodies from all four sub-components in this systems map. Informants recognised this as "probably an unnecessary reduplication for political and bureaucratic

reasons" *(Professor of Pathology 284).* This view reflects that of the Shipman inquiry that appraisal, "would offer no greater protection to patients than that afforded by existing systems" and "that the public was being duped by the revalidation test of a doctors' fitness to practice (Smith, 2004: 1050).

The multiple accountabilities, which are indicated in the systems map, and the diverse loci of control would suggest that there are institutional contradictions between on the one hand responsible autonomy with the duty of government to provide high quality public healthcare, and on the other hand professional autonomy which is based on deeply-held beliefs around the norms and values of the medical profession. There remains institutional dissonance within the NHS, perhaps characterised by Ouchi's contrast between bureaucratic and clan control. However well techniques of mock bureaucracy succeed in modifying the institutional rules, this will not eliminate these contradictions.

Whilst incompatible institutions can and do coexist in the NHS, both clan and bureaucracy tend to resist change being, "stability-oriented rather than change-oriented" (Bate, 2000: 499). Nevertheless change in medical governance is inevitable and it is "evolving away from professional autonomy due to environmental changes" (Fahey, 1994: 77) and these environmental changes are driven by the public and political demands for greater public accountability. This should encourage an emphasis on the quality of clinical services "by locating the responsibility for that quality along defined lines of accountability" (Davies & Mannion, 1999: 2).

It can be theorised from the data in this thesis that there are structural deficiencies in the control of medical performance in the NHS in England. Two healthcare studies, but in entirely different contexts, have stimulated the search for a new governance structure based on Mintzberg's (1980) elements of organisational structuring. Fahey (1994) studied the changes in professional autonomy in the practice of medicine in the US for-profit sector, whilst Unger *et al.* (2000) sought to find appropriate organisational structures for pluralist medical governance in developing countries. Both studies suggest that former models of bureaucratic and collegial control do not fit the current environments and find the governance architecture is "unfit to match [the government's] policy environment or yield the expected outcomes" (Unger *et al.*, 2000: 1006). Thus both contexts are entirely different from this thesis, but the Mintzberg's framework that they use justifies serious consideration, since "the specific configuration of particular governance practices shape the scope for action and agency of the medical profession" (Kuhlmann & Allsop, 2008: 174).

Mintzberg identified five basic configurations, in which the components of the strategic apex, the middle line, the operating core, and the techno-structure and support staff are assembled differently. These five modes are simple structure, machine bureaucracy, professional bureaucracy, divisionalised and adhocracy but he recognised that, "some organizations will inevitably be driven to hybrid structures as they react to contradictory pressures" (Mintzberg, 1980: 322). The simple structure can be rejected since the NHS is too complex and the machine bureaucracy (based on mass production) may also be rejected since the complex outputs from hospitals cannot be standardised.

The NHS is no longer a professional bureaucracy (Fig. 6.2), if it ever was.

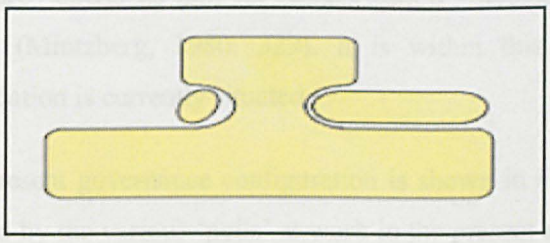

Fig. 6.2 A professional bureaucracy (Mintzberg, 1980: 334)

This organisational configuration is based on skills and knowledge that can only be learned through extensive training which leads to the high autonomy of the operating core, with weak vertical and horizontal integration and little technical supervision. The 'pulls' identified by Mintzberg are that the strategic apex (government) pulls towards centralisation whilst the operating core (the medical profession) pulls to professionalise. Thus, "health professionals tend to defend their autonomy against the influence of the central apex" (Unger *et al.*, 2000: 1009). This is legitimised by "the telling of stories about the nature of medical work, which persuades non-doctors, especially patients and public, of the legitimacy of the doctors' claims" (Fox, 1957: Cited in McDonald, *et al,* 2008: 10). This counterfeit legitimacy brings with it "the power to define how we are to judge the outcome of these activities, and in turn the opportunity to make claims which serve to reproduce the legitimising" (Fox, 1992: 131).

Evidence from the data in this thesis does identify some features of a professional bureaucracy, but doctors recognise the changing environment and accept the need for new forms of governance - *'we are just really bad at regulating people.'* (Consultant, 102). Fahey (1994) also rejects professional bureaucracy arguing that medicine is not so democratic and recommends a structure based on professional oligarchy. This is described

as few decision makers in a strong centralised professional leadership, acting on behalf of others. However, the data here do not support this conclusion.

The middle line was strengthened under the Conservative initiatives towards marketisation, consumerism, performance measurement and, especially, managerialism. Mintzberg argues that the middle line (hospital management) favours limited decentralisation but draws power from the strategic apex. There are insufficient data in this thesis to comment on this since no surveys or interviews were conducted with NHS managers. Under Labour the techno-structure was strengthened, progressively extended and often brought under the direct control of the strategic apex, represented by the Department of Health. The techno-structure "exerts its pull for standarization - notably that of work processes, the tightest form" (Mintzberg, 1980: 329). It is within this component that appraisal linked to revalidation is currently situated.

The present governance configuration is shown in Fig. 6.3. The institutional dissonance is created by the various 'pulls' at work in the present structure and the increasing dominance of the techno-structure, which is becoming the locus of control for medical governance. The current configuration sees the boundaries between Mintzberg's different elements becoming more porous. Some of the support staff, such as nurses, technicians and pharmacists, are becoming part of the operating core as part of multi-disciplinary medical or surgical teams. Evidence is exemplified by the following observation:

> *"Trying to build on what's been happening in pockets around the NHS for years: Doctor A trusts Nurse B, so Nurse B takes on more tasks and it lasts for a while, but one of Doctor A or Nurse B go and the thing breaks down. And what we're trying to do is to say, 'Well if it can work for those two, it can work for everybody or most places, and let's start expanding roles.'"*
>
> (Manager 117)

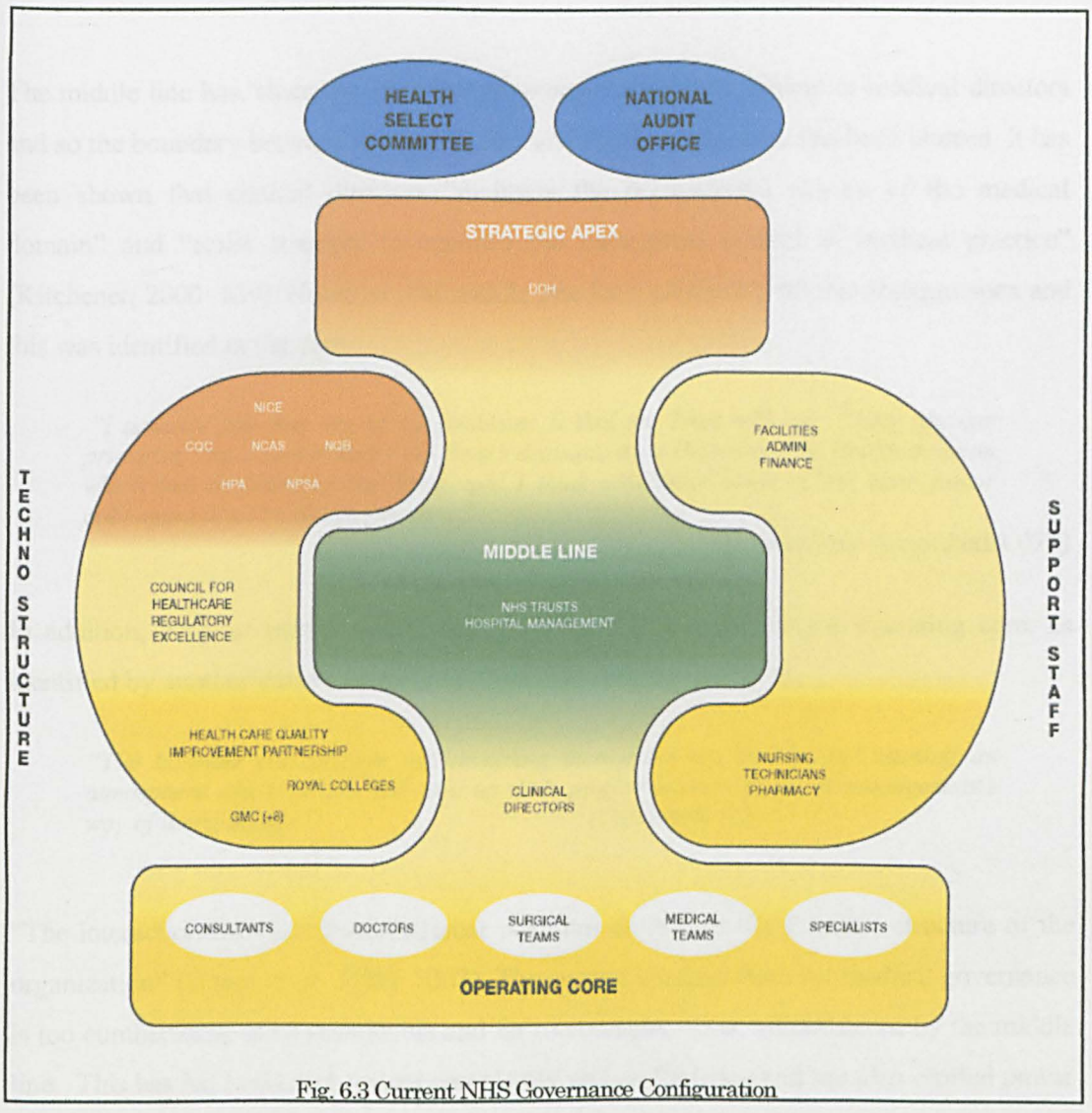

Fig. 6.3 Current NHS Governance Configuration

The strategic apex is taking greater control of the techno-structure with the proliferation of government regulatory bodies responsible to the Department of Health such as Care Quality Commission (CQC), National Quality Board (NQB), National Patient Safety Agency (NPSA) or National Clinical Assessment Service (NCAS). Predominant amongst these is the Council for Healthcare Regulatory Excellence which is the regulator of the nine medical regulators. However, regulation is still firmly situated within the medical professions own governance system. One interviewee considered that appraisal was "a part of the regulation. It is a sort of self-regulation because [it is still] within the medical profession itself. It is not somebody coming from outside" *(Associate Specialist 002)*. Therefore, "the best defence against external controls is the active and visible exercise of a system of self-regulation" (Fitzgerald & Ferlie, 2000: 734). Indeed, more than other European countries in the UK "there is a significant flow of authority throughout the system" (Unger, *et al.*, 2000: 1011) and "the procedures which do exist are largely controlled by doctors" (Allsop & Mulcahy, 1998: cited in Salter, 2007: 265).

The middle line has, since the Thatcher government, included clinical or medical directors and so the boundary between the middle line and the operating core has been blurred. It has been shown that clinical directors "maintain the occupational closure of the medical domain" and "resist attempts to enhance the managerial control of medical practice" (Kitchener, 2000: 129). However, the middle line feels pressure from the strategic apex and this was identified in the data:

> *"I actually feel that one of the problems is that the Trust will say, 'These are our priorities,' but it isn't actually the Trust's decision, it's a Department of Health decision, which has devolved to the Trust, and I think sometimes some of my more junior colleagues don't realise the amount."*
>
> (Consultant Anaesthetist 078)

In addition, hospital management is transmitting this pressure to the operating core, as identified by another interviewee:

> *"The hospital management are involving themselves too deeply and causing an atmosphere where people will give up their professionalism to fit the management's way of doing things."* *(Consultant 02)*

"The interaction between these different positions determine the dynamic structure of the organization" (Unger *et al.*, 2000: 1007). The current configuration for medical governance is too cumbersome to be sustainable and far too complex to be administered by the middle line. This has led to control system complexity and inefficiency and has also created power distance and hierarchical tensions between the different regulators, with failures to implement fully the control mechanisms. Dame Janet Smith argued that, "the onus of checking a doctor's fitness has passed from the [General Medical] Council to the appraiser and the clinic governance system within the NHS, yet neither of these systems was fully established" (Kmietowicz, 2005: 1145). Salter (2004: 117) argues that "medicine's system of self-regulation constituted an invisible world which paralleled, and remained largely aloof from, the political vicissitudes which constantly shake the all too apparent world of the NHS." These two parallel control systems, by government and by the professions and both located in the techno-structure, have not been fully integrated, resulting in institutional contradictions.

Nevertheless the increased porosity of the boundaries between the different Mintzberg components in the current governance configuration may allow the evolution of a new hybrid form that is legitimate, sustainable, based on partnership and cooperation, being flexible enough to accommodate a diversity of approaches and institutional logics. There is room for manoeuvre, according to Fahey (1994: 86) who differentiates two levels of

autonomy, namely "the practice of medicine (patient care) and the physicians' medical practice (business and management aspects)." Doctors may be more willing to give up organisational autonomy but are likely to defend their autonomy over patient diagnosis and treatment. Sharpe & Faden (1998: 53) suggest that the physician's superior knowledge "heightens their responsibility for safeguarding patients" having "a professional and moral obligation to do everything possible to benefit the patient" (op. cit.: 50).

Thus, professional self-regulation and the exercise of management control over professionals have, essentially, different functions. From the management point of view the perception of quality of service seems particularly concerned with value for money and efficiency. From the professionals' point of view, their perceptions of "themselves as guardians of clinical and professional standards and the best clinical" needs of patients, is related to the importance they place on the treatment provided to individual patients (Davies, *et al.*, 2007: 21).

The present governance structure is unsustainable both organisationally and, in the current climate, financially. It also lacks legitimacy, according to the data in this research. Therefore the final section of this chapter proposes a tentative framework that moves toward a new governance structure indicated in Fig. 6.4. The aim is to increase flexibility in order to accommodate a range of structures and approaches at the meso- and micro-levels. It needs to demonstrate greater legitimacy, sustainability and be based on partnership. The tensions around multiple accountabilities, especially to parliament and to patients should be reduced, as should its complexity and areas of duplication. The new framework is not designed to be a blueprint but as a tool for dialogue around professional autonomy.

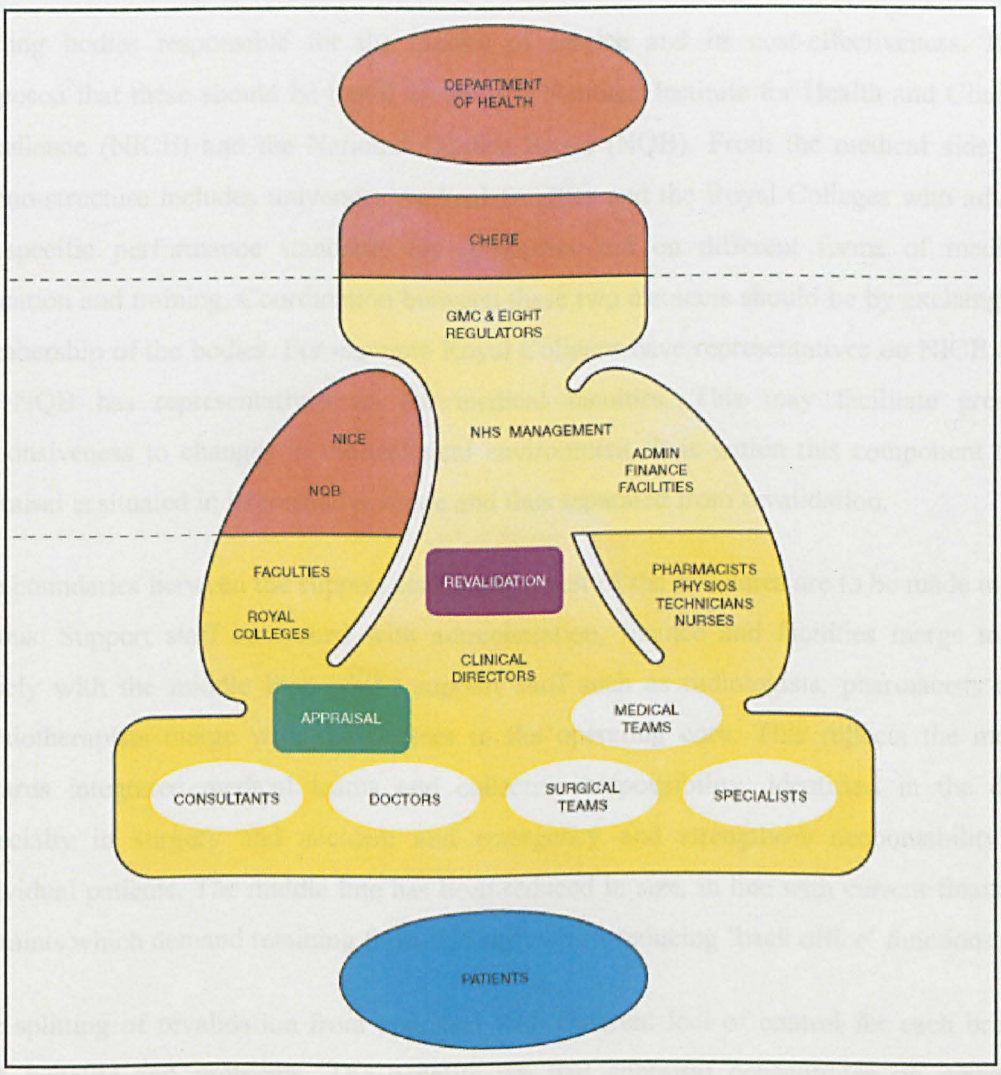

Fig. 6.4 Tentative framework for a new governance configuration

The first major change is the divorce of the Department of Health (DoH) from the governance structure, whilst still retaining some degree of control over quality of service and regulation. This should reduce central government interference in operational matters. So the Council for Healthcare Regulatory Excellence (CHRE), which advises the DoH and is accountable to parliament, sets the standards for and monitors the eight professional regulators including the General Medical Council (GMC) which retain regulatory control over their own professions. Thus revalidation is located within the main spine of the structure and is administered by the NHS management but is a vertical form of control involving clinical directors professionally in the process.

The second change is the reduction in the size and complexity of the techno-structure, with its duplication and reduplication. This component is divided into two elements. From the government side the various QANGOs and agencies should be consolidated into two over-

arching bodies responsible for the quality of service and its cost-effectiveness. It is proposed that these should be based around the National Institute for Health and Clinical Excellence (NICE) and the National Quality Board (NQB). From the medical side the techno-structure includes university medical faculties and the Royal Colleges who advise on specific performance standards for specialists and on different forms of medical education and training. Coordination between these two elements should be by exchanging membership of the bodies. For example Royal Colleges have representatives on NICE and the NQB has representatives on the medical faculties. This may facilitate greater responsiveness to changes in the technical environment. It is within this component that appraisal is situated in its formative mode and thus separated from revalidation.

The boundaries between the support staff and the rest of the structures are to be made more porous. Support staff concerned with administration, finance and facilities merge more closely with the middle line, whilst support staff such as radiologists, pharmacists and physiotherapists merge with the doctors in the operating core. This reflects the move towards integrated medical teams and collective responsibility, identified in the data especially in surgery and accident and emergency and strengthens accountability to individual patients. The middle line has been reduced in size, in line with current financial restraints which demand retaining front-line staff whilst reducing 'back office' functions.

The splitting of revalidation from appraisal with different loci of control for each brings both benefits and problems. The benefits are that appraisal concentrates on personal development without the fear of the loss of the licence to practice, which was strongly emphasised in the interviews and surveys. It would then create less motivation for playing 'tick-box' games and greater encouragement for reflections on practice, also identified in the data is the benefit of making appraisal very specific to the individual disciplines and tailored to individual practice profile (Davies *et al.*, 2005). It should be based on peer-review and team self-assessments, mediated by clinical directors. Thus appraisal would be a "formative process conducted by trustworthy peers" (Lewis *et al.*, 2003: 459).

The main disadvantage is that there would now be two separate processes for appraisal and revalidation, both of which share some of the evidence collected. This impinges on valuable clinical time. One solution would be to have a graduated response to revalidation, using "varying degrees of depth" as suggested by Brown *et al.* (2003: 157) who advocate that "all individuals could be screened using a basic data set and a deeper more-probing process could be put in place where necessary." This would support the existing informal means of peer control over poor performance which the data show to be common practice.

This proposed framework for NHS medical governance should be judged by a range of criteria, first amongst which should be its utility in reducing the identified institutional dissonance. It should be more response to external environmental changes without the need to restructure, which has been the usual response up to now, where complexity is met by yet more complexity. The framework, which should be sustainable, legitimate and flexible and reconcile multiple level accountabilities, might form the basis for productive dialogue between the partners in the provision of high quality healthcare as a hybrid form of control based upon partnership. The main conclusions are now addressed in the final chapter.

Chapter 7

CONCLUSIONS, IMPLICATIONS, LIMITATIONS, CONTRIBUTION AND FURTHER RESEARCH

7.1 Review of the study

This thesis is a study of different UK governments' initiatives between 1979 and 2008 to control the medical performance of doctors in the NHS in England to enhance patient safety, improve healthcare delivery and cost-effectiveness. Chapter 1 introduced the long-standing question of the control and accountability of doctors within the health service that has always been an issue for the State. The importance of the topic was identified as public policy concerns over poor quality standards, inequitable distribution of services, lack of consumer responsiveness, inefficiencies and loss of control of escalating expenditure, and little public accountability of the medical profession.

Chapter 1 identified the main research question as: *To what extent is the government able to control the clinical performance of doctors in the NHS through appraisal?* And set this in the context of the power struggle between the State and the medical profession. It suggested several underpinning research questions around the changing dynamics of the professional autonomy of doctors in light of the calls for the reform of medical regulation, as illustrated in the appraisal discourse. One mechanism that the UK government believes, both implicitly and explicitly, to be instrumental in improving the medical performance of doctors is the imposition of mandatory appraisals leading to revalidation. This research has evaluated the efficacy of appraisal as an NHS control mechanism to improve service delivery, centralise accountability, and weaken self-regulation and implicitly to promote organisational culture change in the NHS.

Chapter 2, through a review of the literature, traced the evolution of reforms under Conservative and Labour governments since 1979, demonstrating ideological shifts between centralisation and decentralisation, between bureaucracy and market forces and between empowerment and greater control. The drivers for Tory reforms reflected the rise of New Public Management in terms of cost effectiveness and value-for-money. These led to initiatives in marketisation, consumerism, performance measurement, managerialism and structural reform. These reforms started to blur the distinction between manager and

clinician, especially through audit which was a major challenge to the professions and their established autonomy (Power, 1999).

However, clinical directors were created and they exercised technical control over colleagues by leveraging collegial relations. Fitzgerald & Ferlie (2000) argued this was professional control more efficient than other forms of external control. Appraisal was first mooted by Griffiths (DoH, 1983) to meet staff aspirations and NHS service needs. Whilst many of the other initiatives did not directly impact the control of doctors, most of them had indirect effects on doctor/patient relations. Tory initiatives around performance measurement began to erode medical autonomy and set the scene for subsequent Labour reforms.

The pace of reform accelerated under Labour with added weight for more state regulation provided by the high-profile medical malpractice scandals, which needed the restoration of government and public confidence in doctors, who had little choice but to cooperate. Labour determined that healthcare quality was its chief policy driver, taking a 'third way' between Tory markets and Old Labour hierarchy. The discourse changed to (clinical) governance to improve service delivery, to enhance patient safety and to control medical performance through greater accountability and transparency, with medical regulators scrutinised by lay members. Many initiatives including targets were given legislative force with corporate accountability for clinical performance, reinforced by national standards bodies such as NICE. One unintended consequence was management 'game playing' to "present their organisations in the best possible light" (Greener, 2008: 204).

Appraisal linked to revalidation emerged as a key control mechanism intended to strengthen regulation, especially to increase scrutiny of poorly performing doctors but also to build on good performance. This policy shift in government intervention in practice licensing extended to the development and surveillance of standards for medical practice, (DoH, 2007a). The chapter provided a critique of appraisal which was seen by some to undermine traditional public accountability, by others as leading to a more centralised, bureaucratic disciplinary model and by many as challenging professional autonomy. But the most telling criticism was that appraisal, "makes no claim that the process will be sensitive (identify poor performance), specific (identify educational needs), valid (reflect actual clinical practice), or reliable (behave consistently across cohorts of doctors)" (Roberts, *et al.*; 2002 cited in Zwanenberg, 2004: 686).

The effects on doctors were seen to be a decline in motivation, spending less time with patients, and attempting to 'buck' the system (Zwanenberg, 2004). Doctors were supportive of appraisal's formative function but suspicious of its summative function. The main focus of this chapter was government control and accountability of doctors. The clinical governance concept was an attempt to "challenge the power of the professional monopolies" in favour of administrative accountability (Woods, 2002: 6). This new architecture was an attempt to get doctors to accept more individual rather than collective responsibility, to maintain the new quality system and to ensure that the audit culture was not just an illusion. One conclusion was that "stripping out the fundamental aspect of professional-led regulation" was not the best way to ensure patient safety (Meldrum, 2007: 2).

Chapter 3 used a force field analysis to explore the power struggle for control between the State and the medical profession over professional autonomy. The chapter reviewed the changing power dynamics around State control of clinical performance and the forces for change and the restraining forces. Using Ouchi's concepts of bureaucracy, market and clan control the chapter explored how their interplay may produce paradoxes and how various modes of control shape doctor and manager relations. Because of these interactions, clans may easily exist within bureaucracies (Jones, 1999). It was found that the strong clan discipline resists tight external monitoring of performance. Commitment (dominates clans), identification (socialised by clans), compliance (by surveillance in bureaucracies; by peer pressure in clans) and reciprocity (relevant to all modes) were seen to be the relevant variables.

The chapter continued by cautiously exploring the medical cultures highlighted by Donaldson *et al.* (2000) and by several medical malpractice inquiries, as influencing adverse events and often emanating from clan control. This was exemplified by the club culture identified at Bristol by Kennedy (2001) which led to the neglect of evidence of poor clinical performance. The medical clan may weaken self-regulation because it is "strong on individualism and weak on team-working and collective responsibility" (Irvin, 2006: 209). It was found that a cultural approach was not a panacea. It is hard to change because of clan dominance, and multiple cultures may be present simultaneously.

Next, the competing concepts of responsible autonomy and professional autonomy were reviewed. The government sought to trade collective for individual responsibilities, as a move towards post-bureaucracy. Responsible autonomy, contrasted with direct managerial control, emphasises governance to enforce professional standards and maintain service

quality by sanctions through new regulators (for example, NICE). But such control was found to exacerbate conflict and diffuse blame. Collegial professional autonomy, even with its supposed lack of a sense of collective responsibility, has remained mostly immune from sanctions, but some authors argued that despite the rhetoric of devolved responsibility, the power balance is shifting towards managers. The responsible autonomy mode of control attempts to trump professional monopoly and subjugates individual needs to those of the organisation.

The perceived shift towards post-bureaucracy under Labour was to overcome traditional bureaucratic rigidity, reduce professional inflexibility through shared responsibility and overcome mock bureaucracy. Mock bureaucracy (or covert organisational non-compliance) in the NHS may be evidenced by the parallel modes of bureaucratic and clan control. It was seen to circumvent those rules and audits which are perceived to have little intrinsic merit or legitimacy and may be used by doctors to resist the tightening of control, in which managers may collude. One manifestation of post-bureaucracy was the shared responsibility at the front-line through the introduction of appraisal linked to revalidation.

The chapter then reviewed the tensions between panoptic surveillance and medical secrecy and between the power of specialised knowledge and the power of information, using Foucauldian concepts, as interpreted by Townley (1993, 1997). To leverage the power of medical knowledge for greater managerial control, the creation of clinical directors may have had the unintended consequence of protecting medical values rooted in professional autonomy. To overcome the culture of secrecy and claims of expertise, panoptic surveillance shifts responsibility from the organisation to the individual and supposedly "turns employees into self-disciplinary subjects of managerial control" (Worthington, *et al.*, 2006: 2). The key feature of the disciplinary powers of surveillance is its supposed ability to regulate behaviour by changing the relationship between observer (management) and observed (doctors at work) who are "totally seen without ever seeing, whilst the agents of discipline see everything without ever being seen" (Foucault, 1979: 202) - governance without direct management intervention.

The chapter concluded with a review of appraisal, which was seen as an attempt to move the medical profession from autonomy to accountability and benchmarking, as part of "the apparatus of bureaucratic control" (Barlow, 1989: 500), and "definitely dictatorial" Garelick & Fagin (2005: 244). Several authors considered appraisal would move regulation from internal clan control to a self-administered unilateral surveillance system and a tool that "links to the organisational system of punishment and reward" (Townley, 1997: 267).

But appraisal seems less powerful a tool than Townley suggests (Worthington, *et al.*, 2006). Because of the restraining forces identified in the chapter, major changes are needed in the NHS if appraisal is to be effective as a form of social control. The shift from bureaucratic control to post-bureaucracy combined with self-regulated control supposedly modified into responsible autonomy was made more explicit by measurable standards of performance under Labour.

Chapter 4, on research methodology, described how the research was conducted and critically evaluated the strengths and weaknesses of the quantitative data collection through two questionnaire surveys and qualitative data collection by semi-structured interviews. There were 5050 questionnaires distributed to Non-Consultant Career Grade (NCCG). 1432 questionnaires were returned completed. This represents a 28% response rate. A total of 1143 questionnaires were also distributed to the Consultant Career Grades (CCG), for those who both acted as appraisees and appraisers. There were 417 questionnaires returned and this represents a 36.48% response rate, higher than NCCG doctors.

The questionnaires intended to answer the research questions about the instrumentality of appraisal and its implementation, the researcher has coded both these sets of questionnaires, and these categories were expected to provide explanations of the data. Five major themes were clustered as:

- *How medical professionals viewed management attitudes to the implementation of appraisal in their Trust*
- *How respondents perceive appraisal in terms of its functionality*
- *Appraisal implementation problems identified by doctors*
- *The strengths and weaknesses of the appraisal processes*
- *Changes in the medical professionals' behaviours in response to appraisal*

Interview data explored on these issues from the perspective of the doctors' responses to appraisals in the NHS organisational context and to provide additional depth to this study. 52 volunteers from both career grades from the total 1849 questionnaires returned. Three major themes emerging from interviews with both career grades, which the researcher has categorised as:

- *How doctors perceive appraisal in terms of its functionality*
- *How appraisal may be used as a change tool to affect the doctor's job satisfaction, motivation and commitment to healthcare.*
- *Changes in doctors' practice in response to appraisal*

Survey and interview data contributed to the assessment of the extent to which appraisal is being used as a control mechanism by the government and the processes which could prevent it becoming an effective control mechanism.

Chapter 5 analysed the survey and interview data and aimed to explore the use of appraisal leading to revalidation as a control mechanism within the NHS and analyse doctors' views and responses to the introduction of professional performance monitoring in healthcare. It addressed five key research questions. The first was the functionality of summative (developmental) and formative (judgmental) appraisal and the data illustrated the tensions felt by doctors between these functions. Also relevant and not well covered in the literature was the importance attached by doctors to the recognition of their individual professional contributions to their Trust. Many informants identified the lack of resources to personal development plans.

The second question around the quality of the implementation of appraisal covered awareness of its aims, preparation time, training given and information provided. It was found that whilst awareness of appraisal's aims was high, its links to revalidation were less clear. Implementation was patchy and in some Trusts lack of management commitment and several cases of no perceived positive outcomes were reported. Documentation found too cumbersome and inconsistent - a maze as one informant observed. Appraisal was inconsistently applied between different grades (33.6% Non-Consultants never appraised compared to 91.8% Consultants) suggesting less equitable opportunities for the former. Similarly, 30.6% of Non-Consultants lacked information whereas 89.3% of Consultants had sufficient and 47.6% of Non-Consultants had been trained, compared to 63.6% of Consultants. Many felt that the training was too basic, with insufficient scope, and was poorly organised and delivered. Several Non-Consultants reported that some of appraisers lacked training or were incompetent.

The third research question addressed in the chapter was the use of appraisal as a control mechanism in the NHS, and this was recognised as such by many informants. The two main themes to emerge from the data were the recognition of poor performance, especially of rogue doctors, and the linking of appraisal to revalidation. Whilst several respondents agreed that monitoring professional performance was important, there were strong suspicions that political forces were driving appraisal. The introduction of appraisal was a 'knee-jerk' reaction by the government to the publication of the inquiry reports into medical malpractices - 'political cosmetics' according to one Consultant. Many felt that because of Shipman and BRI the government was prompted to increase external scrutiny of doctors.

One GP killing his patients had subjected all GPs to government control argued one interviewee, with another claiming that everyone was paying the price for BRI malpractices. One considered that appraisal was a meaningless paper exercise to allow the government "to claim that it is 'doing something' to prevent another Shipman/Ledward etc." *(Consultant 14).* But "extreme cases make bad precedence" *(Associate Specialist 001).* One respondent suggested that the current appraisal process is "probably an unnecessary reduplication for political and bureaucratic reasons" *(Professor of Pathology 284).*

Revalidation was "conceived to detect unacceptable clinical performance" (Pringle, 2003: 437). Even with limited data evidence, it was suspected that poor performance is too multi-faceted to be addressed by such a simplistic device as appraisal alone, lacking in effectiveness, practicality, rigour, validity and fairness. Several thought it ineffective in weeding out rogues, lunatics and oddballs, who may be easily able to perform a good appraisal and not "comprehensive enough to pick out particularly bad performance if their colleagues are not aware about it" *(Consultant 178).* There was insufficient evidence to suggest that appraisal linked to revalidation is effective in controlling doctors' performance. However, one interviewee expressed positive views about revalidation, because "the question especially asks 'Are you up to date?'" *(Consultant 003).* "As a self-reflective process it is valuable. As a means to protect [the] public from lunatic doctors, I don't think it is" *(Associate Specialist 001).* Many interviewees recognised that appraisal should be linked to internal processes such as the Clinical Governance framework.

The fourth research question addressed was the feasibility of controlling doctors given the nature of their work. Whilst the questionnaires and the interviews did not directly address this question, nevertheless there was significant comment around this subject, directly and obliquely, for example observations around the difficulty of collecting valid data on specialised and difficult-to-measure procedures such as anaesthetists and even sufficient data on clinical activity recorded by the hospital, as well as assessing such intangibles as doctor/patient relationships. One informant felt that, "managers have little or no idea of the jobs of doctors working in their Trusts" *(Consultant Pathologist 197).* Proxies were created based on changes in individual performance and changes in the organisation. Assuming that it was possible to control the medical performance of doctors, and then there should be some evidence of changes in their performance and evidence of organisational change.

The data showed that many informants did not identify significant changes in their behaviour. Only 28.8% of doctors intended to improve their appraisal next time, with one indicating it was a "total waste of time,' taking time away from clinical work. One

consultant said that cancelling clinics to find time for preparing the appraisal was an option. Several argued that appraisers did not have an understanding of the nature of their work, especially rheumatology and opthalmics. Mostly tellingly, one doctor claimed that management was not aware of the clinical significance of appraisal and did not appreciate the nature of doctors' work. Nevertheless some informants said that appraisal led to self-reflection but failures to resource individual development plans had negative impacts. Several informants agreed that appraisal had been developmental in that colleagues looking out for each other may provide a self-regulating horizontal control mechanism. Overall, the analysis does not produce significant evidence that appraisal has an impact on the improvement of professional behaviour.

The second proxy for appraisal being an effective NHS control mechanism was that it leads to organisational changes and improved patient safety. Several interviewees indicated that organisational change was inhibited because of increased conflict between medical staff and management because of the emphasis on targets. One doctor claimed that appraisal was being used to target individuals "with no positive effect on patient care." However, there were converse views that appraisal as part of the clinical governance loop would improve clinical practice but it had to be based on a fuller understanding of the nature of the work that doctors do. Whilst there was an implicit presumption that appraisal may promote culture change in the NHS, it probably needs to be integrated with other management approaches, but the data do not indicate what such measures should be.

The fifth and final research question reviewed in Chapter 5 concerned the factors working against appraisal as a control mechanism. Here the data provided plentiful evidence of three sets of factors, around loss of institutional professional autonomy, reductions individually in job satisfaction, commitment and motivation, and organisationally with the operationalisation of appraisal. Firstly, changes in professional regulation were the matter that most concerned the doctors, although many recognised the deficiencies in the current self-regulation system and accepted the need for greater public accountability. However, many recognised detrimental effects on professionalism by replacing collegial relations with hierarchical managerial relationships. Some saw that passing responsibility to external scrutiny, often driven by politics, has gone too far and would damage professionalism. The tight form of surveillance proposed might lead to defensiveness and the damaging of morale, which might be detrimental to the patient.

The many interventions, some without wide consultation, from government in the last two decades changed medical culture for the worse. In this study, several doctors reported the

interventions to be detrimental to job satisfaction, the motivation and commitment of doctors. Coupled to this were the adverse media attention and the decline in respect for doctors, leading to greater anxiety, dissatisfaction and resentment. Imposed external scrutiny was considered to have led to disempowerment. These factors were said by some to have changed the attitudes of more junior staff who seem to care somewhat less for patients. These effects on doctors individually might lead to passive resistance to appraisal. Many interviewees questioned appraisal's effectiveness in identifying poor performance since it was "just a paper exercise" and that poor doctors could perform well in appraisal.

Organisationally the implementation of appraisal was found to be deficient but it has not been possible to determine how far these are teething troubles and how far they are endemic issues. The data exposed lack of fairness in allocation of time, training offered, the distinctions between different grades of doctor, choice of appraiser and weak communication between management and medical staff. Another data also showed lack of efficiency, lack of feedback, poor resourcing, rushed processes, cumbersome paperwork and lack of standardisation. The final concerns were around the validity, reliability and relevance of the data collected for appraisal. These organisational factors may not be easily resolved especially as various modes of resistance may be employed by doctors, often passively.

Chapter 6 sought to broaden the discussion of the empirical findings in relation to the theoretical frameworks and to illustrate the implications that the findings have for the development of a more theoretically-based understanding to test the degree of such an interaction between theory and practice. Main focuses are on responsible versus professional autonomy, on (post-) bureaucracy interacting with mock bureaucracy, and on panoptic surveillance versus the power of medical knowledge and how these theories and concepts fit with the survey and interview data.

The chapter continued with a review of similar research (Redman *et al.*, 2000; West *et al.*,2002; Lewis *et al.*, 2003; Davies *et al.*, 2005; McKinstry *et al.*, 2005; Boylan *et al.*, 2005; Cornish, 2006; Colthart *et al.*, 2007; Shaw *et al.*, 2007; McGivern & Fairlie, 2007; Chamberlain, 2010). These studies were similar in subject matter to this thesis and comparisons were undertaken in order to locate this study in the relevant reaserch landscape. It was found that whilst the data here accords with many of the findings in the work of other scholars, there were significant differences in approach.

Attention was then given to the main research question about the extent to which the government is able to control the clinical performance of doctors in the NHS through appraisal. The data indicated that the appraisal instrument currently in force is not necessarily a predictive model for change in the NHS, despite the finding that some changes have been effected. There is a danger of attaching too much significance to the changes that could be brought about by appraisal leading to revalidation. The conclusions from this section are covered in Section 7.3. However, from the data emerged the deficiencies in the current medical governance structures, to which many informants alluded. This led to the use of the governance lens to make better sense of the data since it appeared that the barriers to effective medical governance are "embedded in policy frameworks and are not simply an outcome of the self-regulatory powers of doctors" (Kuhlmann & Allsop, 2008: 184).

The chapter continued using a governance lens to analyse the opportunities and constraints on the control of clinical performance that the current structure and policy frameworks impose. The multiple accountabilities created by these systems with 13 governments regulatory and quasi-regulatory bodies, and nine professional regulators generate multiple loci of control, leading to institutional contradictions. Applying Mintzberg's (1980) five basic configurations of organisation to illustrate current NHS clinical governance showed that the institutional dissonance is created by the various 'pulls' at work in the present structure and the increasing dominance of the techno-structure, which is becoming the locus of control for medical governance. It that appears the present governance structure is unsustainable organisationally, financially and in legitimacy, according to the data in this research.

Chapter 6 concludes with the development of a tentative framework that moves toward a new governance structure, based on Mintzberg. Such a new structure intends to increase the flexibility to accommodate a range of approaches and to respond to changes in the environment without major reconfiguration. To gain acceptance such a framework must demonstrate greater legitimacy, sustainability and genuine partnership. The new framework intends to offer a new avenue to reduce the tensions around multiple accountabilities between government and doctors, especially to parliament and to patients. The framework should reduce complexity and eliminate duplication.

7.2 Main Conclusions

Key conclusion of this thesis is that although appraisal linked to revalidation (ALR) has produced a new platform for transparency and closer control and accountability over doctors, it only partly achieves its intended aims given the nature and complexity of medical work and the various roles doctors perform. It has not been necessarily well received by the profession, who have shown that they are capable of subverting it, both actively and passively, and in some cases have done so. Evidence indicated that doctors perceived ALR as a policy that has been oversold within the current socio-political context and the continuing public demands on NHS services.

Many of the doctors surveyed and interviewed for this research argued that ALR was being introduced for two suspect reasons. The first was for purely political purposes, to quell public and media questions and concerns about the (apparently poor) quality of healthcare provision and patient safety. The second was to more closely regulate professional practice through what is in effect a subtle method of surveillance and control designed to increase managerial power over the profession and give the State control over the work of doctors.

The evidence generally supports the implied criticisms of Roberts *et al.* (2002) who pointed out that currently appraisal "makes no claim that the process will be sensitive (identify poor performance), specific (identify educational needs), valid (reflect actual clinical practice), or reliable (behave consistently across cohorts of doctors)" (Roberts, *et al.*, 2002 cited in Zwanenberg, 2004: 686).

The second conclusion is that the distinctions between bureaucratic control and clan control suggested by Ouchi were found to be insufficiently nuanced, according the findings from the data which suggest altogether more complex inter-relationships between the two. However, the tensions between bureaucracy and clan in the NHS were confirmed at least partially in the data. This was found particularly around the issue of surveillance, said by Ouchi to be a fundamental means of bureaucratic control. Evidence confirms Barlow's (1989: 512) conclusion that the "formal appraisal systems had come to be seen as bureaucratic and defending, concerned more with regulation and containment than with induction and development in career progression." The data are very limited on clan control and doctors were more prepared to comment on bureaucratic control than on clan control. Whilst Ouchi's concepts may have relevance at the macro-level, it seems that a different and more fine-grained representation of bureaucratic and clan control at the micro-level is warranted.

The third conclusion is that Friedman's (1977) concept of responsible autonomy replacing direct control has been identified in the data. It can be concluded that the responsible autonomy/professional autonomy discourse has been identified in the data and that the concepts interact with the data well. It seems that responsible autonomy is unlikely, from the limited evidence, to replace professional autonomy. Indeed the data indicate that the desire to control the labour process of the medical profession may "concentrate blame and conflict" (Klein & Maynard, 1998: 1). Many interviewees saw ALR not as a benign technical-rational performance assessment method but as a means to convey the message about what it now means to be a 'good,' useful and productive clinician. What concerned informants most was that ALR was in effect an affront to their traditional medical autonomy and professionalism. The fear of sanctions in the form of reluctance to re-licence in cases of failure in the appraisal process is likely to result in outcomes that demoralise clinicians and generate resistance. Moreover, this research showed there has been some resistance to ALR, in different forms. Overall, it is suspected from doctors' responses that the current appraisal process (if linked to revalidation) is a poor tool for the detection of rogue doctors and lacks functionality for improving medical performance.

The fourth conclusion is that the interactions between (post-) bureaucracy and mock bureaucracy and the data were sufficient to support these concepts. Mock bureaucracy was seen to be common-place as a means of protecting doctors' professional autonomy and individuality. Panoptic surveillance was found from the evidence not to be as effective as a means of control as many authors suggest, indicating that the concept is somewhat limited here. This indicates that appraisal as a form of control is perhaps necessary but not sufficient to achieve its aim of controlling the clinical performance of doctors. It would seem that appraisal in the NHS as presently constituted is a sophisticated management strategy to regulate and control. Much of the medical profession is aware of this and, according to some interview evidence, doctors are likely to passively resist, while appearing to conform by 'ticking boxes.'

Therefore, the research has concluded that the current appraisal process needs a fundamental reassessment otherwise it might damage professional morale and motivation. This is likely to lead to strong resentment of increased scrutiny and tighter external control, which will potentially threaten patient safety. Informants indicated that appraisal was deficient for evaluating doctors' work and lacked credibility as a realistic measure of performance, and thus as a tool to control medical performance it was less likely to achieve its aim to improve healthcare delivery, despite its perceived potential effectiveness as a means of development for doctors.

The fifth conclusion is that the empirical findings in this study are equivocal as to whether the exclusive use of appraisal will be sufficiently robust for the anticipated improvements in the NHS control systems. However the data do confirm the view that "appraisal is a rather blunt tool with which to judge effort and value" (Coates, 2004: 569). It was suggested that NHS appraisal is a tangible example of the intangible disciplinary power of surveillance by imposition of a system from other business sectors into the world of healthcare. Such control mechanisms reflect an ambivalent structure of governance through 'soft bureaucracies' (Courpasson, 2000). The doctors' main concern in this study was that the design of the current appraisal process has created anxiety and resistance. Evidence indicated it was considered as 'a paper exercise' 'box-ticking games' 'ritualistic' 'mock ritual' and bureaucracy process, denying the power of panoptic surveillance. This study showed that some doctors expressed the opinion that the extra paperwork would lead to the practice of more 'defensive medicine' and 'reward bad practice' (MORI, 2005), for example by encouraging them to spend less time with patients in order to fill in the paperwork that would secure their future. Similar conclusions were reached by Levenson, *et al.* (2008) and McGiven & Ferlie (2007).

The data also show that while appraisal, as a technical management tool may generate the disciplinary power of surveillance to influence doctors to change and hence control predictability as well as accountability of the medical performance; with a minimum of human resource intervention to achieve the organisational gain. This type of surveillance was seen to generate additional intra-professional power, possibly leading eventually to a degree of intra-professional conflict. For example, the pressures exerted by one of the appraisal criteria around the relationship with colleagues provides some ground for the argument that peer appraisal may in some instances potentially lead to peer pressure. This might manifest itself in pitting one doctor against another or measuring themselves relative to others. This is the power effect to which Townley (1993) alludes, in the sense that appraisal leads to people feeling they are being watched and thus becoming watchful of themselves. In other words, in Foucauldian terms, this is a 'self-disciplinary' approach, but the evidence suggests that it can be resisted.

The sixth conclusion, from a review of similar research to this thesis, is that whilst the data here accords with many of the findings in the work of other scholars, there were significant differences in approach. This thesis is more about control mechanisms and appraisal being used as an exemple of one control mechanism in tension with professional autonomy and the medical clan cultures. The study has suggested that the current NHS clinical governance structural deficiencies have created multiple accountabilities and diverse loci of control.

This has led to intuitional contradictions between responsible autonomy promoted by the government to ensure high quality public service and professional autonomy based around the norms and values of the medical profession. These may aggravate conflict between the government and NHS doctors. The evidence has shown that "an increasingly complex system for ensuring accountability can undermine the professionalism it is supposed to safeguard. And doctors may feel less inclined to behaviour altruistically if they are excessively scrutinised" (Rosen & Dewar, 2004: 46).

By applying Mintzberg's (1980) five basic configurations to illustrate the present governance configuration in the NHS, it was shown that institutional dissonance is created by the various 'pulls' at work in the present structure and the increasing dominance of the techno-structure, which is becoming the locus of control for medical governance. The present governance structure is unsustainable organisationally and financially and lacks legitimacy. However, the current configuration sees the boundaries between Mintzberg's different elements becoming more porous, which give an opportunity for reconfiguring clinical governance.

The final conclusion is in the form of a tentative framework that moves towards a new clinical governance structure. The first major change is the decoupling of the Department of Health from direct interference in the governance structure, whilst still retaining some degree of control over quality of service and regulation. This should reduce central government interference in operational matters. The second change is the reduction in the size and complexity of the techno-structure, with its duplication and reduplication. From the government side the various QANGOs and agencies should be consolidated into two over-arching bodies, responsible for the quality of service and its cost-effectiveness.

The third change is the splitting of revalidation from appraisal, with different loci of control for each. The advantages are that appraisal might concentrate on personal development without the fear of the loss of the licence to practice, which was strongly emphasised in the interviews and surveys. It would then create less motivation for playing 'tick-box' games and greater encouragement for reflections on practice. Also identified in the data is the benefit of making appraisal very specific to the individual disciplines and tailored to individual practice profiles (Davies *et al.*, 2005). The main disadvantage is that there would now be two separate processes for appraisal and revalidation, both of which share some of the evidence collected. This impinges on valuable clinical time, but could be reduced by having a graduated revalidation system.

7.3 Implications for policy

The implication of empirical findings is that appraisal by itself is less likely to be effective as a control mechanism for doctors where self-regulation has long dominated. Current appraisal processes show some degree of confusion and ambiguity, as appraisal practice in the NHS was adapted from industry sectors, in which self-regulation was not the issue and there is no relicensing threat after having been appraised. Therefore, if the appraisal process eventually links to revalidation, there is more research needed into the dynamics between appraisal and medical self-regulation within the NHS.

The main policy implication is that the current medical governance structure must be simplified and made more legitimate, sustainable and realistic. The Department of Health should be divorced from the NHS management structure to reduce operational interference. The medial profession should recognise the changing public arena and "Medicine could choose to act independently of the state and itself recognise the emerging reality of the patient as health care consumer, rather than rely on government policy-making as the engine of change" (Salter, 2003: 934). The regulatory systems which have grown cumbersome, complex and confusing; it should be simplified and codified, with less duplication.

Appraisal should be decoupled from revalidation if the control of clinical performance is to become a partnership between the paymaster and doctors. In this way the formative function of appraisal is likely to be fully endorsed by the medical profession, provided development plans are fully resourced. To ensure the validity, reliability and legitimacy of the process, the core criteria laid down by the General Medical Council should be supplemented by specialism specific performance measures with standards set by the professional regulators and the Royal Colleges, and overseen by the National Quality Board. The criteria should recognise the work that doctors do and the needs of different grades in the profession.

Reliability may be improved by re-assessing the doctors' individual portfolios, which they themselves assemble, and their functionalities with some degree of third-party verification. This will require "the inclusion of more objective evidence matching specified criteria with greater subsequent examination of the outcomes of appraisal" (Colthart, *et al.*, 2008: 87). Evidence in this study has indicated potential problems in this issue. The validity of the current seven categories of evidence (GMC, 2001) should be reassessed. Data in this thesis suggest that 'health' as a cause of underperformance should be addressed by the NHS occupational health systems, that 'teaching' should be removed and added only where

applicable, that 'patient feedback' and 'relationship with colleagues' should take a less prominent role since some evidence shows that these are open to manipulation. More prominence should be afforded to team working, which is becoming more common in the NHS.

To reduce excessive paperwork a free-form system should be established in order to avoid a dogmatic 'work dairy,' which will only add to a doctor's day-to-day workload. Greater use should be made of peer reviews, which are likely to present more realistic measures. The current system relies too much on individual responsibility within a hierarchically coordinated bureaucracy, which means that appraisal is "unlikely to meet the needs of organisations which, for the most part are less well coordinated and more organically based on teamwork and conflict, than the bureaucratic system model supposed." (Copping, 2001: 21).

More consultation, more research and more planning is needed to establish revalidation, independent of appraisal, as a mechanism to be combined with other NHS management processes, such as incident reporting. The locus of control should be diffused between clinical directors, NHS management (as the system administrators) and the Council for Healthcare Regulatory Excellence.

7.4 Limitations, contribution and further research

Limitations

There are several limitations, which might affect the findings of this research. First, the empirical component of this work was based on a limited number of participants both NCCG and CCG. No claim is made that that was intended to be a representative sample. Given the geographical scale of the country, this study lacks breadth in coverage, which consequently makes it unwise to generalise from the empirical findings. Nevertheless the sample size was much larger than similar studies. This study on how doctors respond to the appraisal process finds, as do Newton & Findlay (1996: 42), that there is a lack of "systematic evidence on the actual working of the appraisal schemes in the longer term."

This is also a limitation with this study particularly around the numerous implementation problems and appraisal's uneven application which were discovered. Only a longitudinal study will be able to determine how far these problems are endemic, which is suggested for some of them in this research, and how far the problems are terminal, insurmountable or persistent (Redman *et al.*, 2000). These authors argue that "employers who have utilised

performance appraisal for longer report fewer problems" (op. cit.: 61). Though contradicting this is the comment, in a study of GP appraisal three years on, stating that "there is evidence that the value GPs attach to or derive from subsequent appraisal declines" (Colthart *et al.*, 2008: 86).

Secondly, the empirical results lack evidence relating to the power struggles between professional power and organisational power – between clan and bureaucracy – over the issue of self-regulation with the current social context. However, the evidence from the current appraisal process has some relevance to the research questions, in respect of the perceived negative effects of the process both in implementation time and resources and in fairness and in the lack of promotion of professional development.

In this study no NHS managers, with the exception of Clinical Directors were interviewed, as they were in Redman *et al.*'s (2000) study of appraisal in one NHS hospital. Similarly, McGivern & Ferlie (2007: 1369) included hospital managers, as well as BMA and GMC staff. This is a serious limitation in this study since it does not allow managerial perspectives on clinical performance, nor does it give the views around the need for control of the medical profession as seen by management which faces political pressures. A further limitation is that the extent of decreasing professional autonomy and increasing bureaucratic control in the current reforms of the regulation of doctors by the appraisal process cannot be convincingly evaluated in this study, because of the sample size and because of the absence of any ethnographic observation.

Contribution

Despite these obvious limitations, this research has contributed to the growing literature on the contemporary concerns with control of medical performance and the practitioners' potential for resistance to these trends, often based on the absence of relevant, specific and professionally agreed standards developed by Royal Colleges. The thesis contributes rich qualitative data around control and resistance in medical regulation and clinical governance of healthcare quality. In particular, it re-emphasises the potential weakness of the panoptic surveillance concepts by demonstrating the measures of tacit and covert resistance utilised by doctors to subvert its aims often employing the techniques found in mock bureaucracy.

The research contributes to the existing research in four respects. Firstly, unlike similar studies, it sets appraisal within the historical and political context between 1979 and 2008 of the struggle between the State and the medical profession over the control of medical performance. In this way, the introduction of appraisal may be seen as the culmination of a range of different initiatives driven by different ideological and political imperatives and

may account for the complexity and confusion that surrounds the current clinical governance structure. This thesis places emphasis on both structure and agency.

Secondly, it identifies the problem of appraisal practice in healthcare especially its conflict with professional autonomy, as the NHS has imported an appraisal process from the private sector, where self-regulation is not the norm and where there are no subsequent re-licensing issues. This adds a new dimension to the human resource management literature around appraisal practice. Therefore, this study offers a starting point for the research upon which such a crucial development must be based.

Thirdly, this study builds upon the work of Fahey (1994) and Unger *et al.* (2000) by applying Mintzberg's (1980) elements of organisational structuring in the search for a new clinical governance structure. This study has proposed a new framework for NHS medical governance. The researcher believes that its utility in reducing the identified institutional dissonances and being more responsive to external environmental changes without the need to restructure, which has been the usual response up to now - where complexity is met by yet more complexity.

Fourthly, in this study of the policy of improving health service delivery by the control and enforcement of regulation of Consultant and Non-Consultant Grades in NHS hospitals in the National Health Service in England, the problematic issues of the doctors' responses to the government introduced staff appraisal process were explored through questionnaires and interviews. The findings contribute empirical evidence for developing a more theoretically-based understanding of the current appraisal process and its defects in regulating and controlling doctors' performance to make professional accountability more responsive, visible and accountable with the ultimate aim of improving health service delivery, especially patient safety.

Further research

Evaluation of appraisal requires further work with a far larger dataset over a longer period of time. When the implementation deficiencies identified here have been rectified, further evidence from doctors may not then be coloured by their concerns over implementation. Further research is necessary to establish the extent to which doctors' complaints about implementation actually express their opposition and implicit resistance to the intensification of control.

A useful extension of this research would be to identify the particular boundaries between professional autonomy (clan control), with the privilege that specialised knowledge creates,

and dominating bureaucratic control mechanisms that demand compliance but diminish professional pride in high standards of performance, by management-led systems of performance management and clinical governance. Further research might address the question of how to reduce such institutional contradictions between these competing modes of control.

Appraisal, if it is de-linked from revalidation, may be modified to assess teams and their impact on clinical performance, since team working is becoming more commonplace in the NHS and has been seen to improve performance outcome. Some research has been undertaken here but more is needed. Also, further study of the relationship between culture and organisational control mechanisms within the NHS merits much greater attention.

These suggestions for further research, although not exhaustive, illustrate the fact that more in-depth and longitudinal research is needed, in the field, of effective medical performance control mechanisms if they are to be beneficial for professional development, organisational efficiency and improved patient safety.

Appendix A: Questions for Semi-Structured Interviews with Consultants and Non-Consultants

What were your expectations of appraisal? How did you feel about being appraised?

Do you feel that Consultant appraisal can impact on clinical care/patient outcomes?

Do you feel that appraisal can impact on individual aonsultant performance? How?

What is your view of the relevance and validity of the data collected/submitted/discussed at appraisal - generally, and specifically, what is your view about data collected for 'relationships with colleagues' and 'relationships with patients'?

Does appraisal support reflection on practice? Were you doing this anyway? Does the organisation support reflection, and if so, how?

Do you feel that appraisal is developmental for the individual?

Do you feel that appraisal is developmental for the organisation? How?

Does appraisal lead to sharing of best practice/ improved communication

How does information gathered through the appraisal process get fed back into the organisation?

How does it support the organisation's overall training and development strategy?

What is the link between appraisal and revalidation? What part does it play in safeguarding patients?

What is the link between appraisal and other internal processes (e.g. clinical governance, audit, reward structures)

In your view, is appraisal a 'good thing' for Consultants? For patients?

FOR APPRAISERS ONLY

Did appraisees, in your view, genuinely reflect on their performance and practice?

What, if any, were the main difficulties involved in conducting appraisals?

How did you feel about conducting appraisals?

Appendix B: Questionnaire for Consultant Career Grades

Section One (General)

1).What is your job title_____

2). Has your trust introduced annual appraisal for Consultants? .....Yes/No

3). Have you been appraised (as a Consultant) within the last 12 months? Yes/No

4). If not, has a date been set for your appraisal? ..... Yes/No

5). What was the grade/job title of your appraiser?_____

6). Are you aware of the aims and objectives of annual appraisal? .....Yes/No

7). In your view, have you received sufficient information about the annual appraisal process?..... Yes/No

8). Who would you contact for appraisal advice or information if this were needed? (please circle)
Trust staff/ Professional body/DOH / BMA /professional colleagues/other

9). Were you given enough time to prepare for your appraisal? ..... Yes/ No

10). How long did it take you to prepare for your appraisal? (please circle) Less that 2hrs/ 2-4hrs/ 5-7hrs/ more than 7hrs

Section 2 (Training for Appraisees)

11). Have you been offered any training (as an appraisee) to prepare you for the appraisal process? ..... Yes/No

12). Have you received any training (as an appraisee) to prepare you for the appraisal process? ..... Yes/No

13). If you have received training, do you feel that the training was effective in preparing you for appraisal? ..... Yes/No

14). If your answer to question 13 is **no**, please state the reasons for your answer_____

Section 3 (Only relevant if you have been appraised)

15). In your opinion, was enough time allocated at appraisal for a full discussion about your professional training and development needs? .....Yes/No

16). In your opinion, were the following seven headings of good medical practice covered sufficiently during the appraisal?

- Good clinical care Yes/No
- Maintaining good medical practice Yes/No
- Relationships with patients Yes/No
- Working with colleagues Yes/No
- Teaching and training Yes/No
- Probity Yes/No
- Health Yes/No

17). In your opinion, was valid evidence presented and discussed? Yes/No

18). If your answer to question 17 is **no**, please state your reasons for this answer: -

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19). Were your development needs identified and discussed? ..... Yes/No

20). Were clear developmental objectives set? . . .. Yes/No

21). Was an agreed strategy developed to meet these needs? ..... Yes/No

22). Are appropriate resources in place to support this strategy? ..... Yes/No

23). Do you feel that your individual contribution to the Trust was recognized through the appraisal process? .....Yes/No

24). If your answer to question 23 is **no**, please state the reasons for your answer_____

25). Were you able to discuss resource issues at your appraisal? ..... Yes/No

Section 4

26). Do you feel that the appraisal process was fair and open? ..... Yes/No

27). If your answer to question 26 is **no** please state the reasons for your answer_____

28). Did you find your appraisal to be a positive experience overall? ..... Yes/No

29). Do you feel your appraisal was conducted effectively? .....Yes/No

30). Do you feel that the appraisal process will effectively support the revalidation process? ..... Yes/No

31). If your answer to question 30 is **no** please state the reasons for your answer_____

Section 5 (NB ONLY RELEVANT IF YOU HAVE ACTED AS AN APPRAISER)

32).For which grades of staff have you acted as appraiser? (please circle)(Consultants/ NCCG Staff/ Doctors in Training/Other)

33). Did you receive training to prepare you for your role as an appraiser? Yes/No

34). If so, was the training effective in preparing you for this role?..... Yes/No

35). If your answer to question 34 is **no** please state the reasons for your answer

---

36). Did the process allow you to sufficiently cover the seven headings of good medical practice with Your appraisee?

- Good clinical care Yes/No
- Maintaining good medical practice Yes/No
- Relationships with patients Yes/No
- Working with colleagues Yes/No
- Teaching and training Yes/No
- Probity Yes/No
- Health Yes/No

37). Did you feel that the evidence produced and discussed was valid?.....Yes/No

38). If your answer to question 37 is **no** please state reasons for your answer ——

39). Do you feel that your experience as an appraiser of others was a positive one? .....Yes/No

Section 6

40). Do you have any concerns about the way in which appraisals are being conducted in your Trust? ..... Yes/ No

41). If the answer to question 40 is **yes**, please state the reasons for your answer_____

42). What, if anything, would you do differently to prepare for your next appraisal?_____

43). How (if at all) could the appraisal process in your Trust be improved?_____

Would you be prepared to take part in a brief face to face, telephone, or email interview to allow us to explore your views and experience of appraisal in more detail? If you are willing to be interviewed (all of which will be anonymised), please provide contact details below, or email your details to Elaine Eades: eeades@liv.ac.uk

Name:_____ Work Address:_____

Tel No:_____ Email address:_____

Appendix C: Questionnaire for Non-Consultant Career Grades

Part 1

What is your grade/ job title?_____

Which Strategic Health Authority does your Trust belong to _____

Has your trust introduced annual appraisal for your grade?..... Yes / No

4) Have you been appraised in your present post within the last 12 months? .....Yes / No

5) If not, has a date been set for your appraisal? .....Yes / No

6) What was the grade/job title of your appraiser?_____

7) What was the relationship of your appraiser to you? (line manager/ other manager / peer /other _____

8) Have you been appraised in any other capacity in the last 12 months? .....Yes / No

9) If so, what was the grade/job title of you appraiser?_____

10) Are you aware of the aims and objectives of annual appraisal?.....Yes / No

11) In your view, have you received sufficient information about the annual appraisal process? .....Yes / No

12) Who would you contact for appraisal advice or information if this were needed? (please circle) Trust staff/ Professional body/DOH / BMA /professional colleagues/other

13) Were you given enough time to prepare for your appraisal? .....Yes / No

14) How long did it take you to prepare for your appraisal? (please circle) Less that 2hrs/ 2-4hrs/ 5-7hrs/ more than 7hrs

Part 2

15) Have you been offered any training (as an appraisee) to prepare you for the appraisal process? .....Yes / No

16) Have you received any training (as an appraisee) to prepare you for the appraisal process? .....Yes / No

17) If you have received training, do you feel that the training was effective in preparing you for appraisal? .....Yes / No

18) If your answer to question 17 is no, please state the reasons for your answer

_____

Part 3

19) In your opinion, was enough time allocated at appraisal for a full discussion about your professional training and development needs?

..... Yes / No

20) Were all seven headings of good medical practice covered during the appraisal?

- Good clinical care Yes/No
- Maintaining good medical practice Yes/No
- Relationships with patients Yes/No
- Working with colleagues Yes/No
- Teaching and training Yes/No
-Probity Yes/No
-Health Yes/No

21) Were your development needs identified and clear developmental objectives set? .....Yes / No

22) Was an agreed strategy developed to meet these needs?.....Yes / No

23) Are appropriate resources in place to support this strategy?

.....Yes / No

24) Do you feel that your individual contribution to the Trust was recognised through the appraisal process? .....Yes / No

25) If your answer to question 24 is no, please state the reasons for your answer

26) Were you able to discuss issues of resources at your appraisal?

.....Yes / No

27) Was valid and relevant supporting evidence presented and discussed?

.....Yes / No

28) If your answer to question 27 is no, please state the reasons for your answer

---

Part 4

29) Do you feel that the appraisal process was fair and open? ..... Yes / No

30) If your answer to question 29 is no please state the reasons for your answer

---

31) Did you find the appraisal to be a positive experience overall?

.....Yes / No

32) Do you feel your appraisal was conducted effective?..... Yes / No

33) Are you satisfied with the way in which your appraisal was conducted?

..... Yes / No

34) If your answer to question 33 is no please state the reasons for your answer

Part 5

35) Do you have any concerns about the way in which your Trust is conducting appraisals? .....Yes / No

36) If the answer to question 35 is yes, please state the reasons for your answer

37) What, if anything, would you do differently to prepare for your next appraisal?

38) How could the appraisal process in your Trust be improved?

Would you be prepared to take part in a brief face to face, telephone, or email interview to allow us to explore your views and experience of appraisal in more detail? If you are willing to be interviewed

(all of which will be anonymised), please provide contact details below, or email your details to Elaine Eades: eeades@liv.ac.uk

Name:_____ Work Address:_____

Tel No:_____ Email address:_____

Appendix D Survey data output 1

Table 5.1 Explanation of NCCG awareness of appraisal
Frequencies of NCCG awareness of appraisal

	Observed N	Expected N	Residual
No	103	218.5	-115.5
Yes	747	218.5	528.5
To some extent	11	218.5	-207.5
Don't know	13	218.5	-205.5
Total	874		

Chi-Square	D. F.	Significance
1729.698a	3	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 218.5.

Table 5.2 Explanation of NCCG who have been appraised in last year
Frequencies of NCCG who have been appraised in last year

	Observed N	Expected N	Residual
No	478	711.0	-233.0
Yes	944	711.0	233.0
Total	1422		

Chi-Square	D. F.	Significance
152.712a	1	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 711.0.

Table 5.3 Explanation of CCG awareness of appraisal
Frequencies of CCG awareness of appraisal

	Observed N	Expected N	Residual
No	3	208.5	-205.5
Yes	414	208.5	205.5
Total	417		

Chi-Square	D. F.	Significance
405.086a	1	0.000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 208.5.

Table 5.4 Explanation of CCG who have been appraised in last year
Frequencies of CCG who have been appraised in last year

	Observed N	Expected N	Residual
No	34	208.5	-174.5
Yes	383	208.5	174.5
Total	417		

Chi-Square	D. F.	Significance
292.089a	1	0.000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 208.5

Table 5.5 Explanation NCCG knowledge of the objective appraisal

Frequencies of NCCG knowledge of the objective appraisal

	Observed N	Expected N	Residual
No	81	463.7	-382.7
Yes	1307	463.7	843.3
Not sure	3	463.7	-460.7
Total	1391		

Chi-Square	D. F.	Significance
2304.387[a]	2	.000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 463.7.

Table 5.6 Explanation NCCG quality of information received about appraisal

Frequencies of NCCG quality of information received about appraisal

	Observed N	Expected N	Residual
No	427	464.7	-37.7
Yes	960	464.7	495.3
Not sure	7	464.7	-457.7
Total	1394		

Chi-Square	D. F.	Significance
981.849[a]	2	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 464

Table 5.7 Explanation of knowledge the objective of appraisal

Frequencies of knowledge the objective of appraisal

	Observed N	Expected N	Residual
No	6	206.5	-200.5
Yes	407	206.5	200.5
Total	413		

Chi-Square	D. F.	Significance
389.349[a]	1	0 .000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 2

Table 5.8 Explanation CCG of quality of information received about appraisal

Frequencies of quality of information received about appraisal

	Observed N	Expected N	Residual
No	45	206.5	-161.5
Yes	368	206.5	161.5
Total	413		

Chi-Square	D. F.	Significance
252.613a	1	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 206.5.

Table 5.9 Explanation NCCG of time allowed for preparation appraisal

Frequencies of time allowed for preparation appraisal

	Observed N	Expected N	Residual
No	216	532.0	-316.0
Yes	848	532.0	316.0
Total	1064		

Chi-Square	D. F.	Significance
3.754E2a	1	.000

a.0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 532.0.

Table 5.10 Explanation NCCG actual used to prepare for appraisal

Frequencies of NCCG actual used to prepare for appraisal

	Observed N	Expected N	Residual
2-4 hrs	260	270.2	-10.2
Less than 2hurs	93	270.2	-177.2
5-7 hrs	268	270.2	-2.2
More than 7hrs	460	270.2	189.8
Total	1081		

Chi-Square	D. F.	Significance
2.499E2[a]	3	0.000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 270.3.

Table 5.11 Explanation of CCG time allowed for preparation for appraisal

Frequencies of CCG time allowed for preparation for appraisal

	Observed N	Expected N	Residual
No	97	202.5	-105.5
Yes	308	202.5	105.5
Total	405		

Chi-Square	D. F.	Significance
1.099E2	1	0.000

0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 202.5.

Table 5.12 Explanation of CCG actual time to prepare for appraisal

Frequencies of CCG actual time to prepare for appraisal

	Observed N	Expected N	Residual
2-4 hrs	116	99.8	16.2
Less than 2hurs	39	99.8	-60.8
5-7 hrs	116	99.8	16.2
More than 7hrs	128	99.8	28.2
Total	399		

Chi-Square	D. F.	Significance
50.293[a]	3	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 99.8.

Table 5.13 NCCG Explanation of appraisal training offered and delivered

Appraisal Training Offered			Appraisal Training Received		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	658	699.5	-41.5	729	696.0	33.0
Yes	741	699.5	41.5	663	696.0	-33.0
Total	1399			1392		

Test Statistics

	Appraisal Training Offered	Appraisal Training Received
Chi-Square	4.924a	3.129b
df	1	1
Asymp. Sig.	0.026	0.077

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 699.5.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 663

Table 5.14 CCG Explanation of appraisal training offered and delivered

Training Offered				Training Received		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	150	206.0	-56.0	170	205.5	-35.5
Yes	262	206.0	56.0	241	205.5	35.5
Total	412			411		

Test Statistics

	Training Offered	Training Received
Chi-Square	30.447a	12.265b
df	1	1
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 206.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 205.5.

Table 5.15 Explanation of opinions on the quality of appraisal training

NCCG Opinions				CCG Opinions		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	155	219.0	-64.0	97	128.5	-31.5
Yes	496	219.0	277.0	160	128.5	31.5
Partial	6	219.0	-213.0			
Total	657			257		

Table 5.15 Explanation of opinions on the quality of appraisal training

Test Statistics

	NCCG Opinions	CCG Opinions
Chi-Square	5.762E2	15.444b
df	2	1
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 219.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 128.5.

Table 5.16 Explanation of CCG training as appraisers received and comments on its quality.

As appraisers received training	Training quality

	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	27	67.0	-40.0	16	34.7	-18.7
Yes	107	67.0	40.0	86	34.7	51.3
Partial				2	34.7	-32.7
Total	134			104		

Table 5.16 Explanation of CCG training as appraisers received and comments on its quality.

Test Statistics

	As appraisers received training	Training quality
Chi-Square	47.761a	1.168E2
df	1	2
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 67.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 34.7.

Table 5.17 Explanation of Adequacy of time devoted to personal development during the appraisal

Non-Consultants	Consultants

	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	157	335.7	-178.7	36	135.0	-99.0
Yes	844	335.7	508.3	363	135.0	228.0
Partial	6	335.7	-329.7	6	135.0	-129.0
Total	1007			405		

Table 5.17 Explanation of Adequacy of time devoted to personal development during the appraisal

Test Statistics

	Non-Consultants	Consultants
Chi-Square	1.189E3	580.933b
df	2	2
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 335.7.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 135.0.

Table 5.18 Explanation of Personal development strategies met in the appraisal

Non-Consultants	Consultants

	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	103	218.2	-115.2	98	92.0	6.0
Yes	747	218.2	528.8	261	92.0	169.0
To some extent	11	218.2	-207.2	6	92.0	-86.0
Don't know	12	218.2	-206.2	3	92.0	-89.0
Total	873			368		

Table 5.21a CCG actual time to prepare for appraisal

Test Statistics

	Non-Consultants	Consultants
Chi-Square	1733.566a	477.326b
df	3	3
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 218.3.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 92.0.

Table 5.19 Satisfaction with the level of resources allocated to meeting development strategies

Non-Consultants				Consultants		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	199	334.5	-135.5	98	84.7	13.3
Yes	470	334.5	135.5	152	84.7	67.3
To some extent				4	84.7	-80.7
Total	669			254		

Test Statistics

	Non-Consultants	Consultants
Chi-Square	109.777a	132.504b
df	1	2
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 334.5.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 84.7.

Table 5.20 Opinion on recognition of individual contributions to the Trust

Non-Consultants				Consultants		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	288	246.0	42.0	143	100.5	42.5
Yes	661	246.0	415.0	252	100.5	151.5
To some extent	7	246.0	-239.0	3	100.5	-97.5
Not sure	28	246.0	-218.0	4	100.5	-96.5
Total	984			402		

Table 5.20 Opinion on recognition of individual contributions to the Trust

Test Statistics

	Non-Consultants	Consultants
Chi-Square	1132.659a	433.602b
df	3	3
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 246.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 100.5.

Table 5.21 whether valid and relevant evidence was presented and discussed at appraisal

Non-Consultants				Consultants		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No	165	325.0	-160.0	30	33.2	-3.2
Yes	794	325.0	469.0	100	33.2	66.8
To some extent				1	33.2	-32.2
Not sure	16	325.0	- 309.0	2	33.2	-31.2
Total	975			133		

Table 5.21 whether valid and relevant evidence was presented and discussed at appraisal

Test Statistics

	Non-Consultants	Consultants
Chi-Square	1.049E3	1.950E2
df	2	3
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 325.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 33.3.

Table 5.22 whether respondents intend to improver their appraisal preparation next time

Non-Consultants				Consultants		
	Observed N	Expected N	Residual	Observed N	Expected N	Residual
No thing	130	215.0	-85.0	17	32.7	-15.7
Yes	499	215.0	284.0	80	32.7	47.3
Don't know	16	215.0	-199.0	1	32.7	-31.7
Total	645			98		

Table 5.22 whether respondents intend to improver their appraisal preparation next time

Test Statistics

	Non-Consultants	Consultants
Chi-Square	592.940a	106.796b
df	2	2
Asymp. Sig.	0.000	0.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 215.0.

b. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 32.7.

Appendix E Survey data output 2

Table 5.4a NCCG awareness of the introduction of appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	874	0.00	3.00	0.9245	0.42946
Valid N (listwise)	874				

Table 5.4b NCCG awareness of the introduction of appraisal
Explanation of NCCG awareness of the introduction of appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	103	11.8	11.8	11.8
	Yes	747	85.3	85.5	97.3
	To some extent	11	1.3	1.3	98.5
	Don't know	13	1.5	1.5	100.0
	Total	874	99.8	100.0	
	Not applicable	550			
	Total	1423	100.0		

Table 5.4NCCG awareness of the introduction of appraisal

Table 5.5a Explanation of CCG awareness of appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	417	0.00	1.00	0.9928	0.08461
Valid N (listwise)	417				

Table 5.5b CCG awareness of appraisal
Explanation of CCG awareness of appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	3	0.7	0.7	0.7
	Yes	414	99.3	99.3	100.0
	Total	417	100.0	100.0	

Table 5.5 Explanation of CCG awareness of appraisal

Table 5.6a Explanation of NCCG who have been appraised in last year
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	1422	0.00	1.00	0.6639	0.47256
Valid N (listwise)	1422				

Table 5.6b NCCG who have been appraised in last year
Explanation of NCCG who have been appraised in last year

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	478	33.4	33.6	33.6
	Yes	944	65.9	66.4	100.0
	Total	1422	99.3	100.0	
	Not applicable	1	0.7		
Total		1432	100.0		

Table 5.6Explanation of NCCG who have been appraised in last year

Table 5.7a Explanation of CCG who have been appraised in last year
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	417	0.00	1.00	0.9185	0.27398
Valid N (listwise)	417				

Table 5.7b CCG who have been appraised in last year
Explanation of CCG who have been appraised in last year

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	34	8.2	8.2	8.2
	Yes	383	91.8	91.8	100.0
	Total	417	100.0	100.0	

Table 5.7 Explanation of CCG who have been appraised in last year

Table 5.8a Explanation NCCG knowledge of the objective appraisal
Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	1391	0.00	3.00	0.9461	0.25298
Valid N (listwise)	1391				

Table 5.8b NCCG knowledge of the objective appraisal
Explanation of NCCG knowledge of the objective appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	81	5.3	5.8	5.8
	Yes	1307	85.4	94.0	99.8
	Not sure	3	0.2	0.2	100.0
	Total	1391	90.9	100.0	
	Not stated	32	9.1		
Total		1423	100.0		

Table 5.8 Explanation NCCG knowledge of the objective appraisal

Table 5.9a CCG knowledge of the objective of appraisal

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	413	0.00	1.00	0.9855	0.11980
Valid N (listwise)	413				

Table 5.9b Explanation CCG knowledge of the objective of appraisal

CCG knowledge of the objective of appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	6	0.4	1.5	1.5
	Yes	407	26.6	98.5	100.0
	Total	413	27.0	100.0	
	Not stated	4			
Total		417			

Table 5.9 CCG knowledge of the objective of appraisal

Table 5.14a NCCG appraisal training offered and delivered

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Offered	1399	0.00	1.00	0.5297	0.49930
Received	1392	0.00	1.00	0.4763	0.49962
Valid N (listwise)	1392				

Table 5.14b Explanation NCCG appraisal training offered and delivered

		Training Offered		Training Received	
		Frequency	Percent	Frequency	Percent
Valid	No	658	47.0	729	52.4
	Yes	741	53.0	663	47.6
	Total	1399		1392	
	Not stated	24		31	
Total		1432	100.0	1423	100

Table 5.14 NCCG appraisal training offered and delivered

Table 5.15a CCG appraisal training offered and delivered

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Offered	412	0.00	1.00	0.6359	0.48176
Received	411	0.00	1.00	0.5864	0.49308
Valid N (listwise)	411				

Table 5.15b Explanation CCG appraisal training offered and delivered

		Training Offered		Training Received	
		Frequency	Percent	Frequency	Percent
Valid	No	150	36.4	170	41.4
	Yes	262	63.6	241	58.6
	Total	412		411	
	Not stated	5		6	
Total		417	100.0	417	100.0

Table 5.15CCG appraisal training offered and delivered

Table 5.11a Explanation NCCG quality of information received about appraisal

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	1394	0.00	3.00	0.7037	0.48867
Valid N (listwise)	1394				

Table 5.11b Explanation NCCG quality of information received about appraisal

NCCG quality of information received about appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	427	27.9	30.6	30.6
	Yes	960	62.7	68.9	99.5
	Not sure	7	0.5	0.5	100.0
	Total	1394	91.1	100.0	
	Not stated	29	8.9		
Total		1423	100.0		

Table 5.11 Explanation NCCG quality of information received about appraisal

Table 5.17a Opinion on the quality of appraisal training

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
NCCG Opinion	657	0.00	2.00	0.7732	0.44036
CCG Opinion	257	0.00	1.00	0.6226	0.48569
Valid N (listwise)	257				

Table 5.17b Explanation of Opinion on the quality of appraisal training

NCCG Opinion				CCG Opinion	
		Frequency	Percent	Frequency	Percent
Valid	No	155	23.6	97	32.2
	Yes	496	75.5	160	67.8
	Partial	6	0.9		
	Total	657		257	
	Not stated	766		160	
Total		1423	100.0	417	100.0

Table 5.17 Opinion on the quality of appraisal training

Table 5.20a NCCG actual time used to prepare for appraisal

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	1081	0.00	3.00	1.8585	1.20621
Valid N (listwise)	1081				

Table 5.20b Explanation NCCG actual time used to prepare for appraisal

NCCG actual time used to prepare for appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2-4 hrs	260	23.9	24.1	24.1
	Less than 2hurs	93	8.5	8.6	32.7
	5-7 hrs	268	24.6	24.8	57.4
	More than 7hrs	460	42.3	42.6	100.0
	Total	1081	99.4	100.0	
	Not stated	362			
Total		1423			

Table 5.20 NCCG actual time used to prepare for appraisal

Table 5.21a CCG actual time to prepare for appraisal

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
No of observed	399	0.00	3.00	1.6416	1.20692
Valid N (listwise)	399				

Table 5.21b Explanation CCG time used to prepare for appraisal

Explanation CCG time used to prepare for appraisal

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2-4 hrs	116	29.1	29.1	29.1
	Less than 2hurs	39	9.8	9.8	38.8
	5-7 hrs	116	29.1	29.1	67.9
	More than 7hrs	128	32.1	32.1	100.0
	Total	399	100.0	100.0	

Table 5.21 CCG actual time to prepare for appraisal

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