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Playing tick-box games: Interrelating defences in professional appraisal

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ABSTRACT

We here examine the introduction of appraisal for senior medical professionals. Our recent qualitative field research found four main experiences of appraisal (developmental, disappointed reflection, defensive assessment and cynical dismissal of appraisal as a waste of time), which we developed into a typology. We argue many professionals 'play tick-box games' to give the impression of auditable practice while continuing to practise in a traditional way. We develop existing theory on the 'audit society', social defences and 'mock bureaucracy' to explain interrelating defences which occur in appraisal as a reaction to the risks and conflict experienced in professional regulation.

KEYWORDS

appraisal ▪ audit ▪ consultant appraisal ▪ medical professionals ▪ mock bureaucracy ▪ new public management

Introduction

This article examines the introduction of appraisal for consultants, the medical professionals who have historically dominated decision-making in the British National Health Service (NHS) (Ackroyd, 1996). Consultant appraisal (CA) has potentially profound implications for medical professional autonomy, for medical practice, including preventing malpractice, and may exemplify wider changes in modes of NHS management.

The study explored CA as experienced in the field from a subjectivist interpretive position, drawing out perceptions of CA in practice. We began the study using bodies of theory on professionals, new public management (NPM), appraisal, learning and knowledge, which were then tested against qualitative data. As we found only a partial fit, we then accessed and developed new theory to explain the novel and unexpected themes which emerged from the data. Common references to audit, targets and tick boxes from respondents led us to explore Power's (1997) theory of the audit society which fitted with our data and provided a useful conceptual framework. Data suggested that individual consultants were anxious about CA. This builds on Power's work by exploring new theory on social defences. This research process moved iteratively between theory and data to create a theoretical framework which was 'parsimonious, testable and logically coherent' (Eisenhardt, 1989: 548) and provided the best trade-off between accuracy, generality and simplicity (Langley, 1999).

The article is organized into seven sections. In the first section, we examine the traditional politics of professional regulation. We then discuss the rise of NPM and the 'audit society' (Power, 1997), which challenge professional dominance by attempting to make professionals' practice more visible. In the second section, we describe the introduction of CA in the NHS and the third section discusses three perspectives on appraisal (developmental, controlling and ritualistic). The fourth section explores theory on ritualistic, social and bureaucratic defences against conflict and anxiety. In the fifth section, we outline our research methods and then (Section 6) discuss the results of the field work. Four main experiences of CA emerged (developmental, disappointed reflection, defensive assessment and cynical dismissal of CA as a waste of time) which are then classified in a typology. Many consultants maintained the invisibility of their practice by playing 'tick-box games'. Finally, the article makes a theoretical contribution by explaining these 'tick-box games' as interrelating defences against the conflict and risk associated with medical professional practice and regulation.

The politics of professional regulation

We start by examining the key concepts of professionalism, NPM and audit-based regulation. Professional power and autonomy have traditionally been associated with collective control over knowledge (Freidson, 1994). Although some professional knowledge is explicit, it has traditionally been predominantly judgement-based. So those outside a profession are not able to comprehend or assess professionals' judgements. Consequently, professionals have

been regulated by their peers on the basis of technical and moral authority – the belief that professionals know and do what is best for the public (Abbott, 1988; Freidson, 1994; MacDonald, 1995; Mintzberg, 1989).

Professional autonomy may be associated with a mixed behavioural pattern of altruism and self-interest (Freidson, 1994; Mintzberg, 1989). Professionals may use autonomy to pursue their own 'project' (Larson, 1977) at the public's and their clients' expense. Professional bureaucracies may be unresponsive to external pressures and unable to control incompetent or indolent professionals (Mintzberg, 1989). Despite these problems, key authors (Freidson, 1994; MacDonald, 1995; Mintzberg, 1989) argue self-regulation is more appropriate than external regulation because of the tacit nature of professional knowledge and practice.

From the early 1980s onwards, NPM-based restructuring of UK public organizations challenged professional dominance, importing private sector ideas such as markets, measurement and management. NPM ideas aimed to make public organizations more efficient and responsive to 'customer' pressures and also professional practice more explicit and controllable (Ferlie et al., 1996). NHS governance under NPM has been described as 'neo-bureaucratic', emphasizing formal rules that define performance (Harrison & Smith, 2003), measurement and assessment against targets and protocols imposed by a remote but active Department of Health (Reed, 2003).

Power (1997: xvi) argues that the rise of audit systems associated with the NPM movement enables the wholesale redesign of governmental steering mechanisms: 'As the Welfare State is increasingly displaced by the Regulatory State, instruments of audit and inspection become ever more central to the operations and identity of governments and politicians'. Audit 'rituals of verification', designed to produce government and societal confidence, dominate public services in the 'Audit Society'. This growth of audit stems from the growth of a 'culture of suspicion' surrounding public sector professionals (O'Neill, 2002). Trust in public sector professionals has been replaced by trust in accounting and audit (Power, 1997). Audit, like medicine, depends upon professional judgement and yet audit is presented as objective and neutral. But audit is not neutral but an active process of 'making things auditable' (Power, 1996). It colonizes and socially constructs environments so that people believe they can and should be measured and audited, undermining the legitimacy of practices less amenable to measurement. Audit systems are self-perpetuating, consuming increasing amounts of resources, and insensitive to their own unintended, dysfunctional and immeasurable side-effects (Power, 1997).

Pressure on British medical professionals to adopt medical audit started with 'Cogwheel' reforms in the 1960s but only after the White Paper,

Working for patients (Department of Health, 1989) was it formally introduced into the NHS. *Working for patients* defined medical audit as a systematic and critical analysis of medical quality based upon predefined criteria, differentiating it from informal peer-review which existed before. It stated that consultants should participate in a form of audit agreed locally between NHS management and professionals but conceded that the quality of medical work could only be assessed by doctors' peers (Dent, 1995).

The introduction of 'clinical governance' (Department of Health, 1998) made NHS organizations formally accountable for safeguarding and continually improving clinical quality. Previous research (Degeling et al., 2004) found that while NHS managers appear positive about clinical governance, medical professionals are indifferent and believe it is unlikely to succeed. Many medical and clinical directors regard clinical governance as a fad and an unjustified intrusion into the clinical domain, more likely to engender a blame culture than empower clinicians to improve quality. So NHS management became focused on implementing guidelines, quality assurance mechanisms and tools to ensure clinical compliance, while medical professionals remain wary.

Medical audit is a good exemplification of the effects of the audit society explored by Power himself (1997). Initially, medical audit satisfied the conflict between managerial and medical expectations through ambiguity. It created new information but this remained private and was not detrimental to the medical profession. Medical audit was not initially intended as a public accountability device but the increasing national policy stress on performance outcome indicators and top-down accountability eventually transformed it from an ad hoc, bottom-up process into a standardized national framework; it was removed from local practice, heightening conflict between management and professionals (Power, 1997).

Many medical professionals resisted NPM style reforms (Ferlie et al., 1996) either through 'gaming' around targets (Harrison & Smith, 2003; Hoggett, 1996; Hood, 2006; Reed, 2003) or superficially 'absorbing' it at the local level (Broadbent & Laughlin, 1998). Professionals have resisted being 'colonized' by audit too. Their doubts about audit's effectiveness create 'pathologies of creative compliance and game playing around targets' (Power, 1997: 121). Professionals collude with auditors to overlook inadequacies in their practices that might undermine confidence. An alternative scenario to that of 'colonization' is 'inverse decoupling' (Power, 1997: 106), where professionals co-opt audit to present their practice as legitimate whilst continuing to practise as before.

CA could be analysed as a more recent example of medical audit which encapsulates the themes in the established academic literature discussed

above. The next section discusses CA in more depth and the contradictory policy context in which it was introduced.

The introduction of consultant appraisal

CA was introduced into the British NHS in April 2001, partly to reassure the public that doctors were adequately regulated following a series of scandals which had undermined confidence in the medical profession (Donaldson, 2006). These scandals may have been 'played up' (March & Olson, 1983) at policy level to push through tighter controls. A government White Paper on medical regulation (Department of Health, 2007) recently ended the professional monopoly over medical regulatory councils, proposing that lay people make up at least half the members.

CA was originally supposed to provide 'a formally structured opportunity for professionals to engage in dialogue and to reflect on how their effectiveness might be improved rather than to catch those performing poorly' (Department of Health, 2000). During the study (conducted between February 2003 and July 2004) appraisal became linked to the 'revalidation' of medical licences by the General Medical Council (GMC), the body which regulates the British medical profession. Thus CA acted both as an assessment and a developmental exercise, despite deep tension between these two functions (Eades & Graham, 2004; McGivern & Adams, 2006; Smith, 2004; Taylor et al., 2002).

Consultants were obliged to provide evidence of 'good medical practice' (GMC, 2000) in their appraisal form, and to discuss and agree this with their appraiser for medical licences to be revalidated. The form contained seven sections relating to 1) clinical care, 2) maintaining clinical practice through continuing professional development and audit, 3) relationships with patients and 4) colleagues, 5) teaching and training, 6) probity and 7) health. Consultants were only appraised by consultants and were allowed to choose or object to a particular appraiser. Medical and clinical directors (consultants in senior managerial roles) were the only managers permitted to view appraisal forms; non-clinical managers were only given access to data on who had been appraised and the contents of their job plans.

During the study, NHS hospitals were measured by their inspectorate (the Healthcare Commission, formerly the Commission for Health Improvement, CHI) for the percentage of consultants who had completed an annual appraisal. Given their responsibility for achieving targets, management put pressure on consultants to get appraisals done, rather than necessarily to do them well.

Following the recommendations of the Chief Medical Officer's review of appraisal and revalidation (Donaldson, 2006), the recent White Paper on medical regulation (Department of Health, 2007: 6) proposes that appraisal should remain central to the revalidation process. Appraisal will retain both formative (developmental) and summative (assessment) elements but there is greater emphasis on the summative aspects 'which confirm that a doctor has objectively met the standards expected'. This policy shift is consistent with the results of our research so our study may have strong policy implications for the design of future medical regulation systems.

Three perspectives on appraisal

This section now explores three perspectives on appraisal: developmental, controlling/Foucauldian and ritualistic. The first perspective stems from much existing literature on appraisal, which is practitioner-focused rather than theoretical. It suggests that appraisal is beneficial to appraisees in terms of career development, and to organizations for performance management. However, this literature commonly makes assumptions about appraisal which are insensitive to context and outcome (Fletcher, 2001; Newton & Findlay, 1996). We need to consider the audit-dominated context in which CA is situated.

The developmental rhetoric and reality of HRM tools, such as appraisal, may diverge (Legge, 1995). Developmental rhetoric accompanies attempts to make professional practice more explicit, accountable and controllable. Any learning may be dependent upon participants feeling 'psychological safety' (Edmondson, 1999). CA was described as a developmental process (Department of Health, 2000), which would give medical professionals space for 'reflective practice' (Schon, 1987). However, Schon warns that most organizations do not provide a receptive context for reflective practice.

Appraisal may alternatively be a control system. Audit-based and remote systems of regulation could be an example of 'governmentality' – constructing what is known about populations as rational and hence manageable and governable (Foucault, 1991). Appraisal may socially construct appraisees (Grint, 1993) and affect behaviour by making aspects of their practice visible, facilitating compliance with specified organizational procedures (Townley, 1993a, 1993b). Newton and Findlay (1996) suggest that appraisal is like an all-seeing 'God' which shapes subjectivity so that, for example, consultants focus on work made visible by categories in CA whilst neglecting other work. These visibilities may affect behaviour by provoking feelings of powerlessness and persecution.

In her later, interview-based work, Townley (1997, 1999) found that professional appraisees resisted appraisal. Although 'institutional logic' suggested that well-managed organizations should have performance appraisal systems, appraisal was 'loosely coupled' (Meyer & Rowan, 1977) with practice (Townley, 1997). Professional resistance to appraisal reflected a clash between the 'practical reason' of professional norms and the 'theoretical rationality' of appraisal (Townley, 1999). Within CA, this may take the form of a clash between tacit judgement-based practice on the one hand and making practice auditable, conforming with protocols and meeting targets on the other.

The third perspective on appraisal is that it is ritualistic. Barlow (1989: 513) argues that appraisal is tolerated where it does not constrain activities: 'Appraisal epitomizes values of efficiency and rationality, enabling the organization to provide a satisfactory account if called upon externally . . . it freed, rather than constrained, dominant power groups to define and deal with reality in their own way.' Redman et al.'s (2000) study of NHS managers found appraisees going through the motions of appraisal, using it as an opportunity to document why they could not achieve their objectives. Ritualistic appraisal (Barlow, 1989) confers benefits upon organizations and appraisees by presenting an artificial and static reality upon changing and unstable forces. Ongoing practice continues despite external pressure to change.

Barlow implies that ritualistic appraisal is consciously constructed for political reasons. It may still contain elements detrimental to dominant power groups. Barlow (1989: 514) warns that: 'accounting data [may] become ends in themselves and endorse the pursuit of myopic efficiency in what becomes the routinized recording of trivialities'. Ritualistic appraisal may additionally be explained as a defence against anxiety and we develop this argument in the next section.

Social, bureaucratic and ritualistic defences

Healthcare systems have commonly been analysed through rational and socio-political lenses. A third and novel perspective on public sector reform is the psychodynamic, which adds an appreciation of unconscious as well as conscious forces (Baum, 2002). The dynamics of organizational (non-)learning may be visible in the interaction between political and emotional factors (Vince, 2001). So, healthcare reforms may fail because they disturb disregarded defences (Bain, 1998; Baum, 2002). When actions do not make rational or political sense, they may have an unconscious

explanation (Baum, 2002). We now outline theory relating to social and bureaucratic defences against anxiety which provide the basis of a novel fourth perspective on appraisal.

Jaques (1955) argued that social systems unconsciously function to avoid depressive (feeling that nothing will ever work) and persecutory (feeling threatened or attacked) anxiety. Drawing on Klein's (1952) work on schizoid defences, Jaques suggested that social systems enable people to split from ambivalent feelings and project hostility on to distant others, to idealize those with whom they identify, and to rationalize so doing. For example, medical professionals and auditors may both feel ambivalent about their practice. However, influenced by pressures to conform to their profession's norms, they may unconsciously externalize this anxiety by blaming other professions for shortcomings and idealizing their own approach. Social defences become institutionalized within 'system domains' (Bain, 1998) involving a constellation of roles, organizational structures, authority systems, accountabilities, knowledge-bases, organizational cultures, professional representation and training.

Menzies (1959) demonstrated how nurses unconsciously used bureaucracy to depersonalize relationships with patients as a social defence against overwhelming anxiety. These feelings are likely to affect medical professionals too; clinical training may encourage detachment and denial of feelings (Hyde & Davies, 2004). Organizational rituals embedded in bureaucratic routines may emerge as defences against conscious and unconscious anxiety (Gabriel, 1999). When social and bureaucratic defences are disturbed, medical professionals' anxiety may be amplified by the concomitant disturbance of social defences against the unconscious feelings about their practice in respect of death and illness.

Gouldner (1954) found that bureaucracy served as a social defence in a gypsum mine by reducing tensions resulting from different value systems. In his analysis, bureaucracy had a number of functions. The 'remote control function' and 'screening function' enabled managers to bypass conflict by imposing impersonal rules. The 'punishment legitimating function' allowed aggression to be expressed through enforcing and resisting rules where 'good employees' could control their emotions. The 'apathy preserving function' enabled miners to work without emotional commitment and meet only minimum standards. Supervisors used the 'leeway function' to secure informal conformance by overlooking certain rules.

Three different patterns of bureaucracy emerged in Gouldner's (1954) study, depending upon whether it was 'legitimate' or 'expedient' to enforce or resist rules: 1) 'representative bureaucracy', for example safety rules, which both miners and management agreed and complied with;

2) 'punishment-centred bureaucracy,' associated with conflict over incompatible values and the channelling of hostility through rules (for example, the 'no absenteeism rule', which managers enforced to meet production quotas and miners resisted because it limited their autonomy); 3) 'mock bureaucracy' was neither enforced nor obeyed but existed solely to comply with external regulation. For example, 'the no smoking rule' was imposed by the mine's insurance company but as smoking presented no actual fire risk, allowing miners to smoke elicited cooperation. As enforcing the rule was both unnecessary and antagonistic, it was neither legitimate nor expedient in practice. Therefore on a day-to-day basis supervisors overlooked the rule in return for informal compliance, but strictly enforced it when insurance inspectors visited. Thus mock bureaucracy served as a defence against conflict over incompatible values (Gouldner, 1954).

Healthcare is affected by pluralistic and often conflicting stakeholders (Ferlie et al., 1996) and by a culture of suspicion and distrust (O'Neill, 2002). Healthcare systems may develop social defences against unrealistic and conflicting goals (Baum, 2002) and risk (Hirschhorn, 1999). Power (1997) speculates that audit rituals may alleviate social anxieties and enable regulators to mask their inability to control professionals. Similarly, Hoggett (1996: 22) suggests that performance management in the public sector provides only the illusion of control 'largely designed to reassure anxious senior bureaucrats'.

Bain (1998) and Hyde and Davies (2004) suggest ritualistic behaviour and systems persist in healthcare organizations as social defences against unconscious anxiety. We speculate that a ritualistic form of CA may occur as a defence against the risk inherent in healthcare practice, incompatible professional and managerial values, unrealistic public expectations, and deeper unconscious fears about practice.

Methods

The article is predominantly based upon 66 semi-structured interviews. We wrote to approximately 700 consultants in two large NHS teaching hospital trusts, inviting them to be interviewed, eliciting 44 volunteers. We then approached others with experience of CA: 10 more consultants, including medical and clinical directors; nine hospital managers; and people at the British Medical Association (BMA), the body that represents medical professionals, and the General Medical Council (GMC). Interviews terminated at a point of 'theoretical saturation' (Eisenhardt, 1989) when consistently no new themes were emerging.

Interviews explored experiences of CA, the wider context in which it was situated and initial theoretical perspectives, as described above, but allowed interesting new topics to emerge. The field researcher, then a PhD student, encouraged interviewees to reflect on their experiences around CA, using his training in counselling skills and questions about feelings and metaphors (see Gabriel, 1999) to elicit less conscious data. Interviews were transcribed and coded using NVivo software.

The article uses narratives extracted from interviews to describe and explain the experience of CA. Individual narratives were not taken at face value and were triangulated with other data. We were conscious that interview-based narratives were situated within the research process; it is possible that interviewees described CA to influence the researcher and further their own agenda. So professionals may have been making the case for 'indetermination' (Boreham, 1983) to protect autonomy. We do not claim that narratives represent any reality relating to CA rather the perceptions expressed by interviewees. However, these accounts may influence the way that CA is socially constructed in practice.

We could have based the article on interesting but atypical narratives, but these outliers may not represent consultants' experiences overall. Quantification of qualitative data is useful for exploring whether vivid stories can be safely generalized (Bryman, 2001; Miles & Huberman, 1994; Silverman, 2001). We inductively categorized and counted the experiences of individuals within a simple typology.

We systematically analysed 54 consultants' interview transcripts using the words, phrases and metaphors used to describe CA to develop labels for categories. To ensure the content of interviews reflected the category label, we also analysed overall perceptions of the utility of i) reflection and ii) completing the appraisal form during the CA process. Next we reduced the number of categories by combining those which were fundamentally similar and a second researcher cross-checked categorizations. We extracted representative narratives from interviews to illustrate categories. Finally, we developed a typology to present our data, discussed further in the results section. Interviews with managers were analysed in a similar way and used to corroborate interviews with consultants, but not included in the typology as managers had not directly participated in CA.

Taken by itself, such categorization and typology creation might oversimplify and impose an artificial order on complex data (Bryman, 2001; Miles & Huberman, 1994). As it was also triangulated with narratives, we nevertheless believe it provides a valid and useful conceptual framework for understanding patterns across the data and puts individual stories in broader context.

Results

The experience of CA broadly fell into four main categories, emerging from data analysis, which we develop into a typology: 1) development; 2) disappointed reflection; 3) defensive assessment; and 4) waste of time. Finally, we review our data on how consultants responded to the threat posed by the visibilities created in CA; they often played 'tick-box games' to avoid making their practice more visible while providing the impression of accountability.

Experiences of CA

1) Development

The first group of consultants viewed CA as developmental both for individuals and organizations:

> Appraisal was useful because it made me look at my own practice, which I hadn't done before . . . I consequently changed my subspecialty . . . I wouldn't have made the change without appraisal. I was actually too comfortable and getting a bit bored . . . and my group, when I looked at it as a whole, would have also got bored if I blocked things by staying in the role.
>
> (Consultant 63)

Appraisal provided a new opportunity for reflective practice and to talk through difficult issues:

> [Clinical] decisions . . . we've had a lot of problems with that here. It was nice to talk about that and hear other people's perceptions.
>
> (Consultant 9)

It also helped consultants to review their practice as a whole and prioritize activities:

> [CA is] a very important moment for deciding where I should be expanding and where I should perhaps be saying no . . . If you say yes and do something badly you serve nobody . . . I think the headless chicken philosophy is a real issue for us.
>
> (Consultant 11)

These accounts fit with the ideal experience of appraisal, as specified in practitioner-focused literature and Department of Health documentation.

2) Disappointed reflection

A second group of consultants initially welcomed CA and found it a useful opportunity to reflect on their practice. However, they were disappointed with the process overall for two main reasons. First, this was because their appraiser was dismissive of CA:

> For me the reflecting stuff was the best part . . . take stock of what's happened . . . look through the file and you see things . . . [The appraisal itself] was a total waste of time. It took about 15 to 20 minutes . . . he's [appraiser] not interested in it . . . he doesn't see that side as particularly useful . . . it was shuffling papers, tick, tick, tick and get it out of the way as soon as possible.
>
> (Consultant 29)

A second reason for disappointment was that organizations were unable to resolve issues highlighted in CA:

> The main strength is that you have to give yourself some time to work out what you're doing and to put that down on paper . . . to talk through . . . The weakness . . . is that things haven't changed . . . what is the point of having appraisal if the things that are being highlighted aren't being changed?
>
> (Consultant 19)

Consultants in this group may have been unrealistic about the changes CA could bring about. Nonetheless, their experience led them to become cynical and pessimistic about both CA and NHS management.

3) Defensive assessment

A third group of consultants viewed CA as an assessment rather than an appraisal, serving as a useful defence against possible future litigation:

> I think it actually is a good defence . . . It's important that doctors are accountable . . . The appraisal system, actually I agree with it . . . things should be written down . . . it's a performance assessment, it's not appraisal.
>
> (Consultant 50)

Overall, consultants' views were mixed as to whether CA would prevent future medical failures. However, this group of consultants appeared to believe that complaints were inevitable (note their use of the term 'when')

but acknowledging and recording problems in CA could absolve them of responsibility:

> A year down the line when things go horribly wrong, and you've either had a nervous breakdown or killed a patient or something, it might actually be quite useful that you said, look, I tried to tell you at the time I wasn't coping.
>
> (Consultant 7)

> It enables you to document a wide range of difficulties . . . so don't blame me . . . you provide me with what is required and I will do it but don't moan at me if it is not done . . . I feel that it's great . . . when somebody makes a complaint about you . . . you've got all the stuff down in writing which you normally wouldn't have.
>
> (Consultant 48)

This group appeared anxious about their powerlessness to prevent things going wrong and being blamed but used CA as a defensive ritual in which they projected these feelings onto the CA process.

4) Waste of time

A final group dismissed CA as 'more work' or 'a waste of time'. Given their previous experience, this group was cynical and suspicious about anything managerial from the start. Accordingly they socially constructed CA as a time-wasting bureaucratic ritual, creating a self-fulfilling prophecy.

> Appraisal is something you should be doing from day-to-day . . . what power does someone have to change the situation for anybody? . . . appraisals that formally happen in the health service are a complete waste of time . . . A ritual just for the point of completing a form so that some bureaucrat has a job.
>
> (Consultant 6)

These consultants dismissed CA as 'another useless target' for the Department of Health which served little practical purpose:

> Appraisal, it's a number-crunching exercise, a target. The Trust has to say it has achieved consultant appraisal, x per cent consultant appraisal each year. That's as far as I can see, it's another useless target.
>
> (Consultant 37)

Many consultants believed that CA had 'potential but it has been corrupted' (Consultant 20) by audit. Accordingly, they complied with it only superficially and engaging with the CA process increased cynicism rather than being a positive and developmental experience.

Typology

The typology below makes overall sense of these consultants' experiences of CA. It conceptualizes CA as involving two activities: i) recording data in the appraisal form, including evidence of good medical practice for revalidation; and ii) reflecting on practice while preparing an appraisal folder and discussing it with appraisers. The horizontal axis of the typology shows the perceived utility of recording data and the vertical axis shows the utility of reflection.

Consultants' views of CA were placed in one of four categories shown in Figure 1. Differences between categories may be relative rather than absolute; some overlap is possible. However, the purpose of categorization is to put the experiences of individuals in overall context and see patterns across data rather than to provide a definitive quantification.

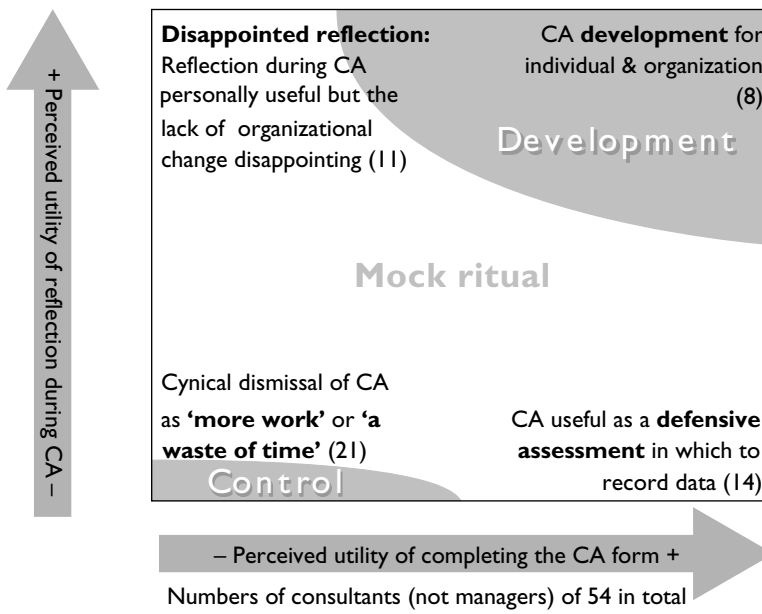

Figure 1 Typology of consultants' experiences of appraisal

The three perspectives on appraisal outlined earlier (developmental, controlling and ritualistic) are shown on the typology and linked to categories. The boundaries between the three areas representing the perspectives are drawn to reflect the authors' judgement about the numbers of consultants who experienced CA in each way. CA was beneficial for the eight consultants in the 'developmental' category and some of those in the 'disappointed reflection' category. CA appeared to control a minority of consultants in the 'waste of time' category. Clinical Director 51 suggested that this minority had 'been allowed to get away with doing not necessarily very little but doing the things they enjoy rather than the things they should be doing'. They were hostile towards CA because it limited their autonomy.

For other consultants CA was more of a mock ritual. The 11 in the 'disappointed reflection' category had initially bought into the 'mock' (superficial) developmental purpose of CA but ultimately they experienced it as a pointless 'tick-box' ritual due to dismissive appraisers and inert hospital processes. This group did not want to use CA as a defence. By contrast, for the 14 in the 'defensive assessment' category, CA superficially appeared to be about improving practice but in practice occurred as a defensive bureaucratic ritual for projecting blame. For most of the 21 in the 'waste of time' category, CA was a mock ritual which gave the impression of regulation decoupled from practice. These consultants dismissed CA before the process began even though it might have been useful to them as a defence. A similar pattern was found among consultant interviewees in both hospitals.

Visibility of practice

CA operates in a context in which NHS management is attempting to make medical professionals' practice more explicit, visible and accountable. Consultants appeared to accept the utility of reflection, but their feelings about the wider appraisal process and its context affected their feelings about doing so during CA:

> The things that actually patients want from professionals are increasingly squeezed off the agenda . . . appraisal, in terms of filling in all these ghastly forms, is again geared towards things that will end up as targets . . . that is the nature of the beast. Well that is not the nature of clinical medicine and the things that are important cannot necessarily be counted.
>
> (Consultant 35)

Consultants were in conflict with the managers running CA over the extent to which medical knowledge and practice could be recorded in appraisal

documentation. In one hospital in particular, this was encapsulated within the new 'job plans':

> There is the issue of what constitutes a fixed session and people were very concerned that it doesn't reflect what their actual work is.
>
> (Manager 13)

Managers believed that consultants were recording data selectively in CA:

> There was a massive discrepancy in the way that the paperwork was completed . . . like the job planning . . . frequently they were filled in incorrectly or not at all . . . there was a fairly clear realization that these are the parts that are for management and were skirted around . . . I don't think people [consultants] have really seen the worth . . . because it hasn't really been rigorously conducted . . . if you set fairly minimal goals then it becomes . . . a tick-box exercise.
>
> (Manager 12)

Consultant appraisers appeared to prefer dealing with issues informally, and only 'in the last resort' formally:

> I don't want to bring people in here to rip them apart . . . if there's something wrong . . . I will talk to them before the appraisal, or raise it in appraisal but I may not document it depending on how I feel it will affect them . . . in the last resort I would bring it up in an appraisal.
>
> (Consultant 56)

Clinical Director 25 argued that 'to take it any further is quite a serious disciplinary matter . . . and can get difficult'. This is particularly the case when conflict and hostility are channelled through formal bureaucracy, as the following accounts demonstrate.

Consultant 49 publicly criticized some consultant colleagues for underperformance. One of these consultants responded by making a bullying allegation against Consultant 49, who was 'put through a formal investigation' which ultimately 'wasn't upheld'. Consultant 49 was 'bitterly disillusioned' by the experience. Having realized the individual risk associated with using formal organizational processes to make changes, she commented: 'I just hide myself in theatre and do my work . . . I retreat into patient care . . . I mistrust any mechanisms within the Trust'. Consequently, she felt 'anxious and a bit cynical' about CA: 'I don't know where this [CA] will go in the context of revalidation and that's my worry.'

Likewise, consultant 48 confronted a consultant colleague for 'abusing the system'. The accused party responded by making a counter-accusation of 'not being impartial', which was ultimately unsubstantiated, but 'found that by complaining about personal issues with me he could get away with all kinds of things' (Consultant 48). The complaints process left Consultant 48 'burnt out and tired and need[ing] a recovery period', hence he moved into a low profile clinical position. He commented about CA that 'nobody wants to write down that they have problems because once the system does get you, even if you're not guilty, it can screw you beyond measure'. Both consultant 48 and 49 also commented on the 'macho' culture in which they worked where openly acknowledging problems was taboo:

> In the NHS, you've been through medical school, you become a consultant . . . there's . . . a macho expectation, that you can deliver all these things and if you try to talk about the limitations . . . you're seen as a wimp.
>
> (Consultant 48)

> It's a very closed culture, very macho, driven, with no systems that encourage openness.
>
> (Consultant 49)

Although these two accounts were exceptional, they were powerful reminders of the potential individual costs of being isolated from the profession and caught up in visible conflicts and formal bureaucratic processes.

The threat of using data recorded in the CA form may coerce consultants who are practising poorly into doing better. Indeed, CA provided impersonal authority so that appraisers could tackle worrying colleagues and taboos which they had been previously unable to address:

> Someone who has a huge NHS practice . . . because with it comes private practice . . . you can't say, look, the reason why you're doing it is because you're very keen on the private practice . . . That sort of thing is pretty taboo . . . if they are frantic or have had a lot of clinical incidents or a lot of complaints or haven't got time to do audit because they're so busy, the appraisal process is a very good way of saying, the reason . . . is because you've got a thousand new patients and perhaps we could reduce that.
>
> (Consultant 29)

> We've actually got some bits of paper now. Everyone has been vaguely worried about this man, but it's never been seen as important . . . Because of appraisal we've actually got this quantifiable thing.
>
> (Clinical Director 25)

However, consultants seemed to avoid making practice more visible to remote regulators unless doing so was useful to their own departments. Some were dismissive of CA, and particularly of providing data in the appraisal form:

> The whole thing [CA] was pretty unnecessary. It was all a question of ticking boxes and finding the right sort of phraseology. I'm afraid it was very much regarded as a process that had to be gone through so that some bureaucrat could file it away somewhere rather than as a positive, enriching, useful experience . . . the actual data we were producing was of very little importance to us . . . I see the NHS essentially as a bureaucratic enemy and I will try and do research independently of the NHS or outside the NHS or without them knowing because all they'll do is try and stop what I want to do.
>
> (Consultant 15)

Consultant 15 perceived 'the divorce is between the senior echelons of the NHS and those of us at the coalface; that includes managers'. He distinguished between 'our local management' with whom 'we work very symbiotically' and the 'Department of Health, who haven't a fucking idea what they're going on about and just send down directives'. This description may well be valid but it could also be seen as a defence, aggression (note his use of strong language) channelled through bureaucracy and blame projected onto the impersonal 'bureaucratic enemy' in the Department of Health.

Cynicism meant that CA became a box-ticking exercise used to provide the right impression of practice:

> If you're cynical you'll say that once you know the goalposts of appraisal it is very easy to play the game . . . tick all the right boxes and not actually improve your standards.
>
> (Consultant 5)

Appraisal may set in motion power dynamics which produce unpredictable effects unrelated to its declared aim of improving individual and organizational performance through the provision of information (Townley, 1993b). A few consultants appeared to have been devoting time and resources to

re-presenting (rather than changing) practice in order to fit with the requirements of CA:

> A number of my colleagues . . . don't have any research . . . they go 'I have a blank here [in the appraisal form], what the hell am I going to do?' . . . we had a dinner . . . One of the consultants brought up the issue of publication . . . we said . . . 'Why don't we make a [name] group?' . . . And then one of them said 'that will give the something that we can put in the box' . . . you have created a falsity . . . We are being organized into something called a collaboration so that somebody can tick a box . . . It's not going to change anything, these guys worked together anyway . . . it has made a falsehood . . . for no other value than to fulfil a bureaucratic requirement . . . Now I'm prepared to play the game for a while to see if something falls out of this . . . I doubt that it has anything to do with the appraisal process.
>
> (Consultant 43)

In knowledge-intensive work where results are hard to demonstrate, workers may develop an anxious preoccupation with how they are seen (Alvesson, 2001). As the passage above suggests, some consultants are anxious ('what the hell am I going to do?') that their practice should appear to conform to the requirements of CA; blank sections arouse suspicion and trigger more questions. Many medical professionals are not changing their actual practice rather they are re-presenting what they do in order to avoid empty boxes in the CA form.

Given the earlier discussion of audit, it is interesting that Consultant 56 should liken CA to sending tax returns via a reliable accountant. He suggests that an appraisal form that 'looks good' and 'accountable' is unlikely to be questioned:

> [CA provides] a tick in a box, I will put it quite bluntly . . . like with the taxman. The taxman can't look at everybody . . . if you send your tax forms from a reliable accountant . . . the chances are much less that you're going to be fished out of the pool and questioned . . . [CA] is working out this same way. Providing it's all there, and it looks good . . . the chance of having problems at the end is very small.
>
> (Consultant 56)

Clinical Director 51 described the 'accountability and transparency' provided by appraisal as 'brilliant . . . it's a confidential discussion . . . for the two or three people involved'. This statement reflects previous research

on inverse decoupling (Power, 1997) in medical audit. This accountability is grounded in 'legal logic' (Broadbent & Laughlin, 1997) and a response to external regulators. Clinical Director 65 commented:

> I'm getting quite a lot of enquiries from the GMC . . . I need to give some pretty well validated information . . . It's one of the few things we've got formally that demonstrates that doctors are participating in a process of quality control . . . appraisal fits with some of the stuff I feed back to the external regulators.

Discussion and conclusion

As the typology suggests, most consultants experienced CA as mock ritual. Interviewees commonly used the language of box-ticking and targets to describe CA, particularly the appraisal form. CA serves to make professional practice more accountable as the basis of revalidation. Yet most consultants played tick-box games to create the impression of accountability, while continuing to practise in a traditional professional way, less visible to those outside the medical profession. Legitimacy provided through the impression of audit was more important than professional development. This makes more sense politically and psychodynamically than it does rationally in terms of benefiting patient care.

Previous research (Dopson, 2005) has shown that innovations in healthcare systems produce rational and also emotional responses from different actors (for example, medical professionals, managers and regulators). These actors respond to innovations by simultaneously playing different games which then interact in complex ways to produce unpredictable outcomes. Theoretically, we explain mock ritual appraisal as the unintended consequence of four main interrelating bureaucratic and social defences.

A first defence occurs when regulators remotely construct CA in auditable terms to bypass medical professional resistance. This is both a political and an emotional defence, protecting regulators from the anxiety caused by conflict with professionals. Professionals cannot contest this kind of regulation overtly because there is no box in which to do so in the appraisal form. CA has a remote control function (Gouldner, 1954) which bypasses conflict.

A second social defence occurs within the medical profession. Unlike Gouldner's (1954) study where smoking in the mine presented no real risk, healthcare is inherently risky. When failures become visible and bureaucratized, even unsubstantiated complaints cause overwhelming anxiety for

the individuals involved. By contrast, the invisibility and collective responsibility associated with professional regulation diffuse professionals' individual anxiety. So the professionalization project is not only about building professional autonomy (Larson, 1977) but the maintenance of professional social defences.

Third, bureaucratic processes can channel blame (Fineman & Gabriel, 1996). When CA fails to prevent adverse clinical incidents, regulators can split from their anxiety about responsibility and project blame onto professionals for not following CA rules, using this failure to justify even tighter controls. Professionals can split from their anxiety about responsibility and project blame onto remote regulators for creating processes that demonstrably do not work in practice, and thereby justify more professionalism. Mock ritualistic CA occurs as a schizoid defence (see Jaques, 1955) 'when things go horribly wrong' (Consultant 7).

A fourth way in which CA occurs as a defence is by mediating between regulators and professionals; enabling both their defences to persist. Professional appraisers use the 'leeway function' to elicit informal compliance, reinforce motivation through professionalism and avoid conflict. In practice, most professional appraisers, like the supervisors in Gouldner's (1954) study, do not respect regulators' distant external authority. Appraisers alleviate appraisees' anxiety by not forcing them to record data about issues which 'can screw you beyond measure' (Consultant 48). Strict enforcement would undermine professional motivation and turn CA into an apathy-preserving social defensive assessment. Within hospitals it is neither legitimate nor expedient to fully enforce CA regulations.

Like the no-smoking rule in Gouldner's (1954) study, which was strictly enforced only during inspections, participation in CA is compulsory and CA forms must 'look good' and 'accountable' (Consultant 56) for medical licences to be revalidated. Mock bureaucratic CA enables professionals and regulators to avoid conflict with one another while maintaining images of control and legitimacy. To a mistrustful public, blind to less auditable side-effects, CA appears effective because targets are 'achieved' and boxes ticked. CA provides reassurance in the face of inherent uncertainty about professional practice.

CA has some useful functions. If those participating in CA own the process and feel 'psychological safety' (Edmondson, 1999), it may provide effective accountability to peers, facilitate reflective practice and provide impersonal authority to address inadequate practice. Yet CA more commonly occurs as an unintended mock bureaucratic ritualistic defence, or when things go wrong as a schizoid defence, against the unknowable, the unmanageable and conflict associated with professional regulation. CA is a

mock ritual that provides the impression of regulation. It is less a conscious conspiracy, as implied by Barlow (1989), but more the unintended consequence of interplay between regulators' and professionals' tick-box games, which occur as defences against anxiety, conflict and blame.

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