

Online Research @ Cardiff

This is an Open Access document downloaded from ORCA, Cardiff University's institutional repository: <https://orca.cardiff.ac.uk/id/eprint/72478/>

This is the author's version of a work that was submitted to / accepted for publication.

Citation for final published version:

Entwistle, Tom ORCID: <https://orcid.org/0000-0001-6457-4749> and Matthews, Elaine 2015. For society, state and self: juggling the logics of professionalism in GP appraisal. *Sociology of Health and Illness* 37 (8) , pp. 1142-1156. 10.1111/1467-9566.12287 file

Publishers page: <http://dx.doi.org/10.1111/1467-9566.12287>
<<http://dx.doi.org/10.1111/1467-9566.12287>>

Please note:

Changes made as a result of publishing processes such as copy-editing, formatting and page numbers may not be reflected in this version. For the definitive version of this publication, please refer to the published source. You are advised to consult the publisher's version if you wish to cite this paper.

This version is being made available in accordance with publisher policies.

See

<http://orca.cf.ac.uk/policies.html> for usage policies. Copyright and moral rights for publications made available in ORCA are retained by the copyright holders.



FOR SOCIETY, STATE AND SELF

JUGGLING THE LOGICS OF PROFESSIONALISM IN GP APPRAISAL

Tom Entwistle

Cardiff Business School, Cardiff University, Cardiff, CF10 3EU, EntwistleT@cardiff.ac.uk

Elaine Matthews

Formerly of the Wales Deanery, Cardiff University.

Abstract

Sociologists repeatedly appeal to notions of altruism, bureaucratisation and self interest in their efforts to explain the changing place of the professions in contemporary society. We treat these three readings as 'institutional logics' key to understanding the way in which doctors respond to the appraisals system at the heart of the UK's approach to revalidation. Our analysis of a survey of 998 GPs working in Wales points to an altruistic commitment to learning and improvement, bureaucratic demands for the reporting of information and self-regarding resentment of changes in the occupational package provided by general practice. But the data also demonstrate that the maintenance of the appraisal regime is dependent on the preparedness and capacity of individual GPs to do micro-level institutional work on all these fronts.

Acknowledgements

We are grateful to Malcolm Lewis, Katie Laugharne, Polly Pownceby and Steffi Williams of the Wales Deanery for granting us access to an anonymised version of the survey they commissioned, designed and managed.

Forthcoming in Sociology of Health and Illness

FOR SOCIETY, STATE AND SELF

JUGGLING THE LOGICS OF PROFESSIONALISM IN GP APPRAISAL

The guiding threads of professional practice are contested. Sociologists tend toward one or other of three readings. The first, and oldest, depicts the professions as 'altruistically serving the interests of others' (Parsons 1939: 458). The second, suggests that the 'professional project', as Larson (1977) describes it, may be more fruitfully understood as an attempt to advance the self-interest of a particular occupational group. The third reading, describes the professions as subject to processes of de-professionalisation (Haug 1975, 1988) or even proletarianisation (Friedson 1984) at the hands of increasingly bureaucratic form of management whether in the public or the private sector. On the basis of a survey of General Practitioners (GPs) working in Wales, this paper asks whether these three readings are consistent with the manner in which family doctors respond to appraisal. Do our respondents' experiences – as captured by a survey – suggest that appraisal has re-energised their vocational commitment to public service; inclined them to see their profession as increasingly undercut by the managerial interests of an increasingly regulatory state; or, caused them to question the personal benefits of being a GP?

The broad church provided by any profession allows for all three interpretations to be supportable to some degree. The truth, in so far as it can be discerned, is likely to reflect a mix of these and no doubt other tendencies. Institutional theory describes fields such as medicine as guided by multiple, sometimes contradictory, 'logics of appropriateness' (March and Olsen 1996: 252, Goodrick and Reay 2011, Allen 2014). Thornton and Ocasio (1999: 804) define these institutional logics as 'assumptions and values' which guide actors in 'how to interpret organizational reality, what constitutes appropriate behaviour, and how to succeed'. Indeed, from a functional perspective, it is hard to envisage sustainable professions without recourse –

at least to some degree – to all three of the logics associated with these readings. Freidson (2001: 181) goes so far as to claim that ‘reality is and should be a variable mix of all three logics . . . The issue should be whether the virtues of each are suppressed by emphasis on the others and their vices excessively stimulated’.

Whatever the balance of, and relationship between the different logics of professionalism, the picture is likely to be a continually changing one as the institutions which define the professional space are periodically renegotiated. Just such a renegotiation has been prompted in the UK by a series of scandals – of which the GP Harold Shipman’s murder of more than 200 of his patients – was the most high profile (Chief Medical Officer 2006; Dixon-Woods *et al.* 2011). As part of its response to Shipman, the UK Government required the profession to introduce arrangements for revalidation – a five yearly review of a doctor’s licence to practise – which requires, amongst other things, that doctors participate in annual appraisal (GMC 2014; Greenhalgh and Wong 2011; Waring *et al* 2010).

The re-negotiation of the professional space prompted by the introduction of appraisal and revalidation takes place at two levels. First, at the field or policy level (Greenwood *et al.* 2002), the designers of the new system had to put in place a set of institutions which would ‘provide assurance for patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise’ (GMC 2014, p.8). But this needed to be achieved within the context of an occupational package – in terms of work, remuneration and autonomy – which remained attractive enough to recruit and retain individual practitioners. According to Freidson’s analysis (2001), functional reform required the designers of appraisal to perform a delicate balancing, or perhaps more realistically a deft juggling, of the three logics of appropriateness.

Second, at the micro level – the focus of this paper – individual GPs needed to work out how to respond to the demands of appraisal and how to represent their response to other parties (Powell and Colyvas 2008). Would GPs use the opportunities provided by appraisal to reflect, learn and in turn improve their practice? Or, would they comply with the formal requirements of the regime, and then complain about the bureaucratisation of the profession? Or finally, would they minimise, or where possible avoid the burden of appraisal, and reconsider their continued employment in an occupation which has become increasingly unattractive? Both their responses, and their representations of those responses, are important because over time and in combination (Dorado 2005), they are constitutive of the informal institutional arrangements which sustain the appraisal system. Although more hum drum than the heroic interventions of those tasked with the formal design of the appraisal and revalidation regimes, every individual response – whether quietly compliant or loudly subversive – is an instance of ‘institutional work’ (Perkman and Spicer 2008) which plays a part in the social construction of the appraisal system. By their actions and representations, individuals contribute, albeit sometimes in very small and perhaps unwitting ways (Dorado 2005, Smets and Jarzabkowski 2013), to the ‘creation, maintenance’ or ‘disruption and change’ of the institutions of the appraisal regime (Lawrence *et al.* 2011: 53).

The paper uses data collected from a survey of GPs working in Wales conducted in 2008, to understand the part which micro-level institutional work plays in the renegotiation of the professional space. This is an issue of increasing significance, not only to GPs in Wales, but to all doctors in the UK and beyond who find themselves subject to ‘a new era of managerial control’ (Dixon Woods *et al.* 2011, p.1453; Leicht *et al.* 2009). The paper is organised in four further sections. The first provides an account of the three readings of the position of

professions in society; the second describes our data set and the way we have analysed it; the third presents our interpretation of the data; while the last section discusses the significance of, and limitations to, our findings.

The three logics of the professional project

Freidson (2001: 17) defines a profession as 'a set of institutions which permit the members of an occupation to make a living while controlling their own work.' Gorman and Sandefur (2011: 278-279) describe those institutions as focused on four central attributes: expert knowledge; technical autonomy; a commitment to serve others; and high status and income. Although most would largely agree with these attributes, commentators provide very different accounts of the assumptions and values underlying these arrangements.

The altruistic account of the professional project has its roots in the work of Durkheim and Weber who portrayed the professions as occupational communities galvanised by a sense of vocation, or commitment, to the service of their clients or society (Parsons 1939). Pellegrino defines altruism as 'that trait which disposes a person to take the interests of others into account in using power, privilege, position and knowledge' (1989: 57). Barber (1963: 672) goes so far as to assert that a 'primary orientation to the community interest rather than to individual self-interest' is one of the defining characteristics of a profession. Wilensky (1964: 140) agrees, suggesting that 'devotion to the client's interests more than personal or commercial profit should guide decisions when the two are in conflict'. For the altruistic account, the archetypal institutions of a profession – embracing long periods of education, ethical codes and elaborate mechanisms for oversight and discipline – function to foster and sustain vocational commitment and reassure society that the profession, and the individuals who practice under its banner, are both expert and trust worthy (Barber 1963, Wilensky 1964, Ritzer 1975). Key to this logic of

organisation is the claim that the tasks performed by a particular occupational group 'are so different from those of most workers that self control is essential' (Friedson 2001: 17). Accordingly, the profession must be organised on collegiate lines – dubbed the 'company of equals' by Freidson and Rhea (1963: 119) – in which fellow practitioners learn from each other, and regulate themselves, free from the distortions of competitive markets and managerial bureaucracy (Friedson 2001).

Commentators writing from the 1970s started to question the altruistic account of professional work. Although not all went as far as Illich (1976: 11) in arguing that 'the medical establishment has become a major threat to health', Freidson (1970: 372) called for limits to professional autonomy observing that while it has 'facilitated the improvement of scientific knowledge', it led to a profession 'blind to its own shortcomings and unable to regulate its practices adequately.' In instrumental terms, the 'monopoly of expertise in the market' (Larson 1977: xvii) could be geared more to advancing the occupational interests of professionals than the greater interests of their clients. From this perspective, professionalism is a 'strategy developed by skilled workers for consolidating and increasing the social distance between themselves and their "clients"' (Wilmott 1986: 558). In such a way, the attributes of the professional project – in terms of the monopoly of jurisdiction and barriers to entry – are not necessary concessions to the development and regulation of knowledge, but devices purposefully used to return a dividend in terms of personal autonomy, social status, policy influence and individual remuneration. In contrast to the picture of the altruistic account of the professions as divorced from grubby market forces, the egocentric or selfish account depicts them as savvy market players who have used their closed jurisdictions to bid up the value of their work.

The third account of the professions builds on the altruistic reading in presuming that the professions are guided, at least in spirit, by altruistic motivation. But, in contrast, to the altruistic account, it describes individual practitioners as distracted from the service of society by the managerial control of hierarchical organisations (Numerato *et al.* 2012). Alongside the interests of the two parties we have described – of the professional providing services and the client consuming them – Johnson (1972: 46) describes a third party as mediating the relationship by ‘defining both the needs and the manner in which the needs are met’. Mediation can, as Johnson explains (1972: 46), be provided by the ‘capitalist entrepreneur’ – as in the cases of accountancy, law and pharmacy in the UK – where professionals are predominantly located within the private sector. Other professions – social work, planning and medicine – are traditionally, at least, housed within the state (although see Waring and Bishop 2013). Irrespective of their sector, however, the bureaucratic take-over theorists describe these ‘corporatized’ professions as ‘subject to the administrative control of managers in a hierarchy’ (Goodrick and Reay 2011: 378). While for some, the bureaucratisation of the professions provided safe haven from the chill winds of the free market (Fielding and Portwood 1980), others describe these bureaucratic masters as imposing a degree of control over their work which amounts to the deprofessionalisation or even proletarianisation (Haug 1975, 1988).

The three accounts of professional work have been used by commentators in a number of different ways. Some treat them as normative templates to generate prescriptions for institutional reform. In such a way, the first functional accounts of the professions identified a series of institutional traits associated with well-established professional groups, suggesting implicitly or explicitly that other occupations could or should aspire to the ideal of altruistic service demonstrated by medicine (Barber 1963). Arguing, from the opposite perspective – that professionals like all individuals are inevitably self-regarding – Friedman (1986: 3) suggests

that 'the world will run best if there is a fundamental framework under which people who pursue their self-interest are led by an invisible hand also to serve the public interest'. Even the bureaucratic model of state employment and control has its advocates. Fielding and Portwood (1980: 48) argue that 'for most professions the interdependent processes of bureaucratization and professionalization have been to the benefit of both themselves and the state'.

Others see these accounts as theorised, but none the less empirically verifiable, descriptions of the fortunes of particular professions; one of which is right and the others wrong. Larson (1980: 171), for example, calls for 'more evidence on tendencies of the labor process' to clarify whether proletarianisation is or is not happening. Picking up this baton in a case study of the changing fortunes of the UK's probation profession, Gale (2012: 835), finds that 'work has been "Taylorized", with initiatives conceived at the centre and executed locally by officers under increased subordination to managerial control.' As government relies 'increasingly on a harder working, less autonomous, less qualified and cheaper workforce', individual practitioners describe 'experiences associated with deskilling and degradation' (Gale 2012: 835). Also writing in this vein, this time specifically about medicine in the United States, Pellegrino (1989: 66) observes that: 'Health providers have been encouraged to become entrepreneurs . . . For the first time in medical history, self-interest has been given legal and moral legitimation and profit has been turned into a professional virtue'. Others still, describe the rise of 'auditing, clinical guidelines, knowledge managements systems, protocols, standards, incident reporting systems' as exposing doctors across the West to increasing managerial control (for a review see Numerato *et al* 2012, p.627).

More recently, scholars have shied away from these relatively straightforward accounts of professional change preferring to recognise that multiple logics of appropriateness can be seen

to cohabit the same professional space. New institutional theory describes the emergence of hybrid or accommodative arrangements in which the logics of market and bureaucratic forms of organisation coexist, in different degrees of comfort, alongside traditional collegiate professionalism (Muzio, Brock and Suddaby 2013). Theorists focus in particular on the negotiation of these arrangements at the field or policy level on the presumption that 'organizational behavior occurs through and is a consequence of taken-for-granted beliefs, schemas and values that originate in larger institutional contexts' (Leicht *et al.* 2009, p.582). In such a way Greenwood *et al.* (2002, p.62) describe field level debates as 'a political process in which the competing interests of subcommunities are reconciled and subjugated on an ongoing basis'.

Consistent with this literature, we presume that the activities of GPs are guided by multiple logics of appropriateness. However in place of a focus on field level negotiations, we consider the daily work of GPs as manifested in their reported experience of the new appraisal system. The 'institutional work' perspective contends that the making or breaking of institutions is not the preserve of high level actors tasked with the policy issues surrounding the introduction of new initiatives like appraisal (Lawrence and Suddaby 2006, Perkmann and Spicer 2008, Muzio *et al.* 2013, Waring and Bishop 2013). But rather, that institutional persistence and change is also negotiated at the micro-level in the daily decisions – 'partaking', as Dorado (2005: 400) describes it – of individual practitioners. From this perspective, not all institutional work is purposive, in which instrumental actors intentionally act to invent, maintain or disrupt behavioural patterns. Rather, institutions are also changed (and maintained) by the aggregate effect of non-purposive actions of individuals focused on their own professional and personal business (Smets and Jarzabkowski 2013: 1304). More specifically, we ask first, do the three logics of – society, state and self – capture the 'material practices and symbolic constructions'

which shape and constrain the behavioural repertoire' (Goodrick and Reay 2011: 373) of individual GPs? And second, what do the appraisal practices of GPs tell us about processes of institutional maintenance and change?

Case, data and methods

The system of annual appraisal was introduced for GPs in Wales in 2003. It requires first, that GPs maintain an online database in which they document, and reflect on their learning and development activities, and second that they meet with a peer appraiser to discuss progress. The designers of the Welsh scheme define it as 'a formative, systematic and regular review of past achievements with constructive planning of future progress' (Preece and Shah 2010: 10). Since 2012 participation in appraisal has been required as a necessary, although not sufficient condition, for the revalidation of a doctor's licence to practise (GMC 2014).

The management of effective appraisal processes is widely recognised within the management literature as promising a number of organisational benefits. West *et al.* (2006: 983) extend this analysis into clinical settings, finding that 'high involvement' policies and practices (including but not limited to appraisal) have a 'statistically and practically significant relationship with patient mortality'. A number of scholars make the point, however, that appraisal systems are only as good as the individual appraisal experience they deliver on the ground. As Murphy and Cleveland (1995: 314) put it, the experience matters because 'an unfavorable reaction may doom the most carefully constructed appraisal system.' Ensuring that appraisal delivers positive reactions is though difficult, even within organisations. 'Most of the time', as Beer (1981: 24-25) puts it, 'particularly at times when it is most needed, and most difficult to do, performance appraisal refuses to run properly'. The challenge of designing and managing an appraisal system are likely to be even more pronounced when applied to GPs, who are, of

course, highly trained, very often self-employed and accustomed to high levels of professional autonomy.

Our analysis of appraisal is based on a survey – made available online to all GPs in Wales before the introduction of revalidation – between January and April 2008. 998 useable surveys were returned giving a response rate of 36%. Respondents were asked to rate their experience of their appraisals on a four point scale and then to explain their ratings and comment more broadly on the working of the appraisal system. 651 respondents commented in some form, providing a total of approximately 38,000 words of comment. Through an iterative process of reading the comments and discussing possible interpretations, we arrived at the three codes described in figure 1. Having applied these codes with different font colours, we calculated the proportions of text for each code by using a word count facility.

Figure 1

Many of the comments were of course brief, cryptic or incidental and therefore impossible to code to our three logics. Approximately 65% of the comments were, however, more extensive and evaluatory in tone. Consistent with the logic of altruistic service to society, some GPs said that appraisal had prompted them to learn and improve their practice. Others however – consistent with the logic of bureaucratisation – claimed that appraisal amounted to unnecessary formalisation which distorted the learning process. Finally – consistent with the self-interest perspective – some complained that appraisal left them feeling personally resentful of the demands made by the job relative to the level of remuneration.

The three logics are distributed across respondents in a number of different ways. The comments of some GPs were entirely consistent to a single code, suggesting that they, as an individual, occupied a particular position at least with respect to appraisal. Such consistency was, however, the exception rather than rule. More frequently – indeed in the majority of cases – we drew on two or all three codes in the categorisation of an individual’s comments. One GP, for example, explained (with our codes in brackets): ‘I find the appraisal process generally more onerous than rewarding [for self] and quite often feel that I am writing things on the template for the sake of filling up space [for state]. However, I suppose it does make me reflect, up to a point, more than I otherwise would do and makes me act on what I identify as areas of need [for society].’

While our analysis is based on a good response rate from a survey of the whole population of GPs, the descriptive reliability of perceptual research is sometimes questioned. There is a danger, either because of differences between respondents and non-respondents or else by virtue of the way in which respondents answer questions, that perceptual data may be skewed toward socially desirable responses (Spector 2006). In such a way, GPs may provide an excessively positive account of appraisal in a bid to tell researchers – or indeed society at large – what they want to hear. Response bias may however work the other way – through so called negative affectivity – where respondents might, for example, give an unduly pessimistic account of their experience of appraisal (Spector 2006). Indeed, GPs may purposively have exaggerated their critique of appraisal in a bid to negotiate improvements in the appraisal system. Although rigorously determining the direction of bias between respondents and non-respondents is problematic, a comparison of the average appraisal scores for commenters and non-commenters suggests that our data may indeed display some negative affectivity. Those

who took the opportunity to comment gave, on average, a lower numerical rating for the value of their appraisal than those who did not comment.

While dogged by problems of bias, perceptual research has the great advantage, however, that it is the only way of discovering how GPs choose to describe their experience of appraisal. As we have seen, individual feelings or reactions play an important part in the social construction of appraisal systems. Those feelings cannot be systematically captured in any other way than through some kind of a self-report of the type that we use. It should be said, however, that we could only code the comments entered into the survey. We are in no position to speculate on the applicability of the three logics to others areas of general practice. Those who express a strongly individualistic response to appraisal may be highly altruistic in their engagement with patients and colleagues. Reactions to appraisal – to the extent that they are captured in the survey – might tell us nothing about broader perceptions of general practice. The next three sections review the comments made by GPs under three headings suggested by the three logic of professionalism.

For society

We identified 50% of the coded comments as consistent with the for-society logic. According to these comments, GPs responded altruistically to appraisal by engaging in a series of learning activities – focused on the acquisition and application of knowledge – which might be expected to improve the service offered to society. Indeed, in what might be taken as definitive evidence of an altruistic motivation, one GP even went so far as to explain: ‘One thing I have NOT found appropriate is to be paid £300 for each appraisal. I always give this to charity, as I consider it immoral to receive money for doing what I should be doing in any case!’

While it might be said that the appraisal regime required GPs to engage in a range of professional development activities, the profession could not compel them to do this in good heart. GPs could, for example, comply reluctantly and then complain about the bureaucratisation of the profession (as indeed a proportion of respondents did); alternatively they could try to avoid the burden of appraisal while complaining that the appraisal processes simply asked too much of them (as indeed a small number apparently did). The majority of the code-able comments did not, however, indicate either of these responses to appraisal. On the contrary, the majority of comments indicated a positive engagement with the opportunities and prompts provided by the appraisal regime. Five learning activities can be distinguished in the comments. We consider each of these in turn.

First, the appraisal system was described by GPs as prompting them to 'look out for', 'help to identify', 'undertake', and even 'complete', 'courses' and 'useful learning activities' that they 'would not normally have considered'. Amongst many examples, respondents suggested, that the requirements of appraisal had prompted them variously to: attend 'a diabetic conference in Birmingham'; 'read more and be more up to date'; 'apply to do the palliative care certificate'; and 'attend a GP update course'.

Second, respondents said that appraisal had prompted them to plan their learning activities more systematically than would otherwise be the case, as one GP put it: 'Without appraisal there would be no deadlines and thus I would probably let things lapse'. Others described appraisal as helping them: 'to focus and develop an overall comprehensive strategy of personal development'; to engage in 'forward planning rather than just taking things opportunistically'. 'More focussed learning', according to one GP meant, 'looking out for suitable resources to

address identified need rather than just doing whatever comes along; It has helped my learning become more focused relevant to my practice’.

Third, GPs said that the formal recording processes of appraisal had prompted them to reflect more both on their learning and their practice. One GP explained:

I spend more time now thinking about some of my everyday activities. [I’ve] changed some aspects of learning eg making notes of articles that particularly influence my practice; the system forces me to reflect on what I have done - the basis of adult learning in writing up my appraisal I find I reflect back on courses etc and this helps to identify learning points; It reinforces that I do learn and am open to change.

Others made similar comments: ‘It’s made me reflect on my work and also document what I actually do’ explained one; ‘it has made me think in more logical analytic way about what I do in general practice’ according to another. Others explicitly attributed improved practices of recording and reflecting to the coercive nature of the regime. ‘If I didn’t HAVE to think reflectively about my learning needs’ one confessed ‘I am not sure that I could guarantee to be able to find time to do this’.

Fourth, appraisal is described as prompting discussions with colleagues. In the first instance, these happen as a formal requirement of the appraisal process itself. The appraisal meeting, as one GP explained, provided a useful opportunity ‘to discuss my work with someone outside the practice’. The formal meeting was, according to another, a: ‘Fantastic opportunity to have protected time with a colleague’. Alongside these scheduled conversations, appraisal was also credited with initiating a broader learning and improvement dialogue. One GP, for example, described: how the formal processes of reflection and planning required by appraisal ‘increases the chance I will pass on useful learning to colleagues’. Appraisal ‘changed learning’, according

to another, 'from something that happens in isolation' to something 'that impacts on and involves the clinical team'.

Fifth, and perhaps most importantly, the for-society comments suggest that GPs used their learning to make a number of changes in their professional practice. Some of these changes were clinical. Appraisal, explained one GP, 'allowed me through significant event analysis, as a way of learning, to effect change in my practice'. Another gave the example of doing an 'audit of my minor ops, maybe I would not have bothered if I did not have to do so'; a third described 'changes in management and prescribing'. Other changes might be better described as managerial. One GP claimed to have 'learnt to take on less work and to delegate better'; another suggested that 'I shall be more understanding of other staff's priorities'; a third thought that: 'Time management has improved since reflecting on this with my appraiser'.

For state

As suggested in our review of the literature, one of the most important readings of the contemporary professions, describes practitioners as increasingly subject to bureaucratic control. We coded 35% of the comments as consistent with this critique. Rather than fostering learning and improvement, these comments describe appraisal as a 'hoop to jump through' or a 'box' to be ticked. The problem, according to one GP, is that 'It's like a minister visiting a town. Obviously all the streets cleaned up, flowers in all roundabouts, red carpet laid out. That is not the norm'. Close analysis of the comments suggests that three distinct lines of reasoning lie behind these perceptions.

First, although focussed on professional development rather than performance evaluation, a proportion of GPs criticised the regime because, it is 'never' in the words of one, 'going to weed

out poorly functioning GPs'. A handful suggested that appraisal failed, what might be described, as the Shipman test. 'If the purpose of appraisal', as one put it, 'is to catch another Dr Shipman, it would not work'. 'Shipman would have flown through it!' explained another. 'Jumping through hoops makes absolutely no difference to my ability to be a good or bad doctor. Dr Shipman, I'm sure, would have been able to pass with flying colours'. For these GPs, the failure of appraisal to identify rogue practitioners stems from the fact that the review processes at its heart are not testing enough, as one GP explained: it's 'not very challenging. I think it could be tougher with the need to justify ones actions'. Another described appraisal as:

a meaningless process – a soft option – it disregards obtaining objective evidence of practice standards and personal performance replacing it with a 'cosy chat' with an appraiser whose own practice and practices may not necessarily stand up to objective scrutiny.

In place of a 'cosy chat', the Shipman test critics called for a: 'Bit more of a stick and less carrot' focused in the words of another on, 'GPs with poor performance'. A view shared by at least three other commenters: 'for weeding out rogues we need exams'; 'old fashioned testing might be necessary to give some rigour to the process'; 'Observation of an extended range of consultations is the only valid way to demonstrate this and as a general tool this is unlikely to be practical'. 'Give up trying to inspire us to ever greater efforts' suggests another GP and 'confine the purpose of appraisal to catching dodgy characters'.

The second source of bureaucratic cynicism stems from a belief that the formal processes of appraisal do not help, and in some cases even hinder, learning and improvement. In the first of these camps, GPs claimed that they were learning anyway and so appraisal just introduces unnecessary formalisation. 'Day to day work makes GP self-reflective', as one explains, 'an artificial prompt to do so serves no purpose'. 'At the end of the day', according to another,

'appraisal is really just another hoop to jump through. If it stopped tomorrow it wouldn't influence how I learn or develop professionally'. An account confirmed by at least two other GPs: 'I was doing the learning process anyway without doing all this boring documentation'; 'I do the learning anyway – accruing the paperwork for the appraisal itself is tedious, time consuming and really only done to "tick the box."'

More damagingly, some GPs claimed that the formalisation of appraisal processes actually damages learning. One GP explained:

I really don't feel that it changed the way I learn or keep up to date, just unnecessarily complicated it, perhaps even hindered it, by using up time in preparation and "reflecting" on things I'd already learnt that could have been better spent in learning/reading about things that I hadn't.

The problem, according to these critics, is that the standardised processes of appraisal fail to do justice to the complex and varied ways in which people learn. Three comments capture this mood: 'Standard issue portfolios are really far too "digital" and "box ticking" to suit an intelligent analogue learner'; 'We are all different shaped pegs and there is not a standard hole for all of us to fit through!'; 'I have had to reflect more, but often feel this is an artificial process and I end up writing formulaic drivel'. A number of GPs claimed that the new appraisal system had displaced traditional seminars 'which are now unfortunately very thin on the ground due to the alteration in post grad structure.' 'My preparation' according to one GP,

was merely ticking the correct boxes for the appraisal process and I did not find any to be particularly helpful. I miss meeting other GP colleagues at academic meetings and feel appraisal has encouraged more isolation. Filling in forms to express our feelings following a course or meeting now seems to be of little value.

The for-state comments we have surveyed so far, suggest that appraisal installed a series of formalised rules and procedures which absorbed resources in a number of ways, but failed to either identify mal-practice or facilitate learning. Dysfunction stems, according to some of the comments captured by this code, from the fact that the formal processes of appraisal were not *really* driven by the intention of improving learning or identifying mal-practice, but rather by the desire to reassure, or at least placate, the demands of politicians insistent that something should be seen to be done. There are, as one GP explained, 'other imperatives than purely educational ones'. Another explains that it 'would be better as an informal discussion without all the paperwork. The point is that Government won't put up with that'. 'They don't trust GPs anymore', as one put it, 'because of isolated bad eggs like Shipman'. 'The whole process', another explains, 'is generated by ivory tower educationalists trying to respond to a political agenda that has nothing to do with how we truly learn'. Acknowledging these pressures, some describe appraisal as an inevitable, and in some senses acceptable, concession to the conflicting demands of different constituencies. Appraisal is, according to one, 'a politically necessary procedure which I fully cooperate with. Our paymasters are thereafter happy and can tick their little boxes'. It is, according to another, 'the only viable option that provides reassurance to society that doctors are safely monitored'. Others still accepted the bureaucracy of appraisal as preferable to other forms of reassurance. 'Frankly', according to one GP, 'if it keeps the public happy, it is better than a big exam'. If 'it has to be done to "prove" I am competent', concluded another 'then this is a fairly stress free way of doing so and probably preferable to exams or being quizzed by the Local Health Board'.

For self

Our final code captures comments consistent with the self-interested account of professional work. We included comments in this code which communicated individual *dissatisfaction* with

the appraisal regime and the occupational package of which it is a part. Although egocentric, the comments give a rather different account of selfish practitioners to that depicted in the literature. These comments point more to a sense of practitioners at their wits end, than of savvy entrepreneurs using their esoteric knowledge to extract economic rent from the state. We coded 15% of the material as consistent with this category. Three varieties of the for-self logic are apparent in the data.

The first is perhaps best described in terms of personal resentment, as one GP put it 'I hate, loathe and detest this whole appraisal system'. But whereas in the for-state logic, resentment is explained by reference to the dysfunctional effects of bureaucracy on learning and improvement, the for-self logic complains simply of wasted time. 'We really are' as one GP put it 'too busy and involved for such navel gazing'. According to the for-self critics appraisal is 'a waste of my time', 'my precious time', 'valuable time', 'my personal time', 'my limited and precious free-time' devoted to a process which is variously described in terms such as 'dreary', 'tedious', 'pointless', 'pedantic', 'chore', 'annoying and unhelpful', 'meaningless twollop' or even 'a pain in the rear'. For some, ego-centrism is explained, or justified, by the impact of the demands of appraisal on work-life balance. 'I have little time', complained one GP, 'to prepare for them and they affect my work life balance adversely'. Another explained at greater length:

I find the exercise tedious and administrative. I learn throughout the year. The appraisal just forces me to document my learning which I feel is a waste of valuable time, I resent the fact that this documentation has to be done in my own time at home.

To date I have had to take annual leave purely for this purpose.

Others complained that appraisal was stressful. In the words of one: 'It has now become another chore to complete in an already stressful and busy working environment'. One GP expressed his/her resentment even more strongly, complaining that: 'I nearly have a

breakdown every year; too much time goes into the preparation for an appraisal and it causes far too much anxiety and lost sleep!' Another reported already to be working 'more than a full time week and this just has to be added in on top at the expense of my family and my mental health'.

The second theme within the code, suggests a transactional perspective on the demands of appraisal. One GP described appraisal as 'a time consuming trip with precious little benefit other than 300 quid'. Asking what was in it for them, these commenters complained that they had seen little benefit from appraisal either in terms of learning or, more strikingly perhaps, in terms of the £300 stipend. As one GP put it, 'Too much time is wasted and the payment we get for it doesn't cover the costs'. The appraisal arrangements amounted, according to another GP, to: 'Parental supervision, asking doctors to do their homework and awarding a £300 lollipop. Obviously we all want to suck it. Mind you we are fools to accept that for several days work'. A view shared by at least one other GP who outlined these criticisms at greater length:

Why is the fee that is paid for appraisal the same as at its inception? There has been no inflationary rise. I consider appraisal to be underfunded work. It is impossible to complete during the working day (even though I am constantly learning through reading, doing internet searches, discussing patients with partners/colleagues etc), so becomes evening work hence making it extra work. I find having to document my learning increasingly frustrating and time-consuming

While not complaining about their fee, other GPs complained according to one that 'personally it has done little for me', while another confessed to 'game playing' to 'get by without particularly engaging with the subject'.

The final theme turned on a principled objection to an unwarranted infringement of professional autonomy. GPs constructed this case in different ways. One GP simply explained 'I do not want to be told I must do appraisal', another that it 'is so annoying and unhelpful, an involuntary imposition, along with so many others, that I intend to get out of General Practice'. Others argued, in slightly more sophisticated terms, that the imposition of appraisal was unjustified relative to their level of commitment and the treatment of other professions. GPs are, as one comment put it: 'very honest and hardworking and still highly regarded by the general public'. Another asked rhetorically: 'Are we such an untrustworthy and lazy lot that it's assumed we learn nothing unless we're forced to?' 'Other professionals', explained another, 'do not have to go through this plethora of hoop-jumping'. 'Ditch it' concluded a third 'and treat doctors as having some intelligence to keep up to date with caring for their patients'. In contrast to the comments we coded as consistent with the *for-state* critique – which acknowledged that bureaucratisation was a necessary concession to political demands for improved self-regulation – the *for-self* comments seemed to reject the very principle of incursions on their autonomy. 'It is just window dressing, making life unnecessarily difficult for GPs' said one. Another complained: 'We provide an excellent service to the public against the government's drive to put us down and curb our pay'. Appraisal is a: 'Total waste of time and resources' according to one GP 'the whole process is a politically driven attack on the professional autonomy of doctors'.

Conclusion

Scholars have repeatedly described the institutional arrangements we call professions in terms of altruism, bureaucratisation and self-interest. Drawing on a survey of GPs in Wales, we asked whether comments about a newly introduced appraisal scheme were consistent with these interpretations. 50% of the comments sat comfortably with our *for-society* logic, in which GPs

described themselves as responding positively to the challenge of appraisal by reflecting on, learning about and ultimately improving their service to society. 35% of the comments were, however, in line with the bureaucratic critique – our *for-state* code – in which centrally imposed rules and processes were described in terms of unnecessary formalisation, wasted effort, and for some, the distortion of learning. While 15% of the comments – captured by our *for-self* code – expressed resentment that appraisal was insufficiently remunerated relative to the demands it made in terms of personal time, stress and reduced autonomy.

A field level analysis of these data suggests that the introduction of appraisal has been something of a success. According to this survey, GPs responded to appraisal more by learning and improving than complaining about bureaucracy and the inadequacy of the occupational package. To the extent that appraisal is an institution designed at field level but experienced in GPs surgeries, these are positive results indeed. The introduction of appraisal – at least before its envelopment in the greater revalidation process – seems to pass a functionality test in that the balance of logics had, at least at the time of the survey in 2008, settled in a relatively favourable position. While there is some merit in this interpretation, it exaggerates the power of policy makers, understates the agency of individual GPs and overlooks the complex ways in which the different logics interact and institutions are built.

A closer analysis of our data points to the dependence of the appraisal process on the day to day institutional work of individual GPs. Seen in this way – the predominance of the *for-society* logic – looks like a more fragile or provisional achievement. GPs are not persuaded – by either the sponsors of the appraisal regime or their direct experience of it – to think monogamously in terms of one logic or another. As we have seen, relatively few individuals drew on a single logic in their description of appraisal. If the GPs comments provide a fair reflection of their practices,

then it is more helpful to see the introduction of appraisal as requiring practitioners to engage in institutional work on three fronts. Societal work is done by those appraisers and appraisees who construct learning and development opportunities out of the formal requirements of the regime. Bureaucratic work involves complying with the duty to record and report information (as a box that needs to be ticked and so forth). Finally, work-life balance work has to be done in terms of changing routines and priorities to find the time to do this societal and bureaucratic work (MacBride-Stewart 2013).

In such a way, the successful introduction of appraisal was dependent, at least to some degree, on the preparedness, power and capacity of individual GPs to do micro-level institutional work on all these fronts. Those individual responses are in part a function, as Waring and Bishop (2013: 154) put it, of the 'structured positions, resources and opportunities' of individual GPs. In such a way there is evidence in these data of quite powerful figures – with a knowledge of the political and professional compromises at the heart of the appraisal system – purposively trying to make the appraisal institutions work (Currie *et al.* 2012). Equally, there appear to be examples of some GPs – perhaps those empowered by approaching retirement – purposively trying to undermine the new institutions of appraisal. The vast bulk of the work, however, is not purposively focused on maintaining or disrupting institutions in this way. As Smets and Jarzabkowski (2013: 1304) put it, 'most individuals are not grand entrepreneurs, but practical people doing practical work to get a job done.' Indeed it is the aggregation of the routine coping activities of individuals focused on the daily challenges of their work – partaking as Dorado (2005) puts it – which determines the shape of the informal institutions of appraisal.

While the nature of that non-purposive institutional work is in part determined by the formal design of the appraisal system, the extent to which individuals respond societally,

bureaucratically or selfishly depends also – according to these data – upon each individuals practical position in their life and work. In such a way, attitudes and approaches to bureaucratic work depend, as Delbridge and Edwards (2013: 15) put it, on the ‘personal biography’ of the individual in terms of their experience, and perceptions, of bureaucracy. Depending upon those current and past experiences, some individuals may have the resources to comply quickly and easily with the formal demands of appraisal, while others – by virtue of different experiences and perceptions – find those same requirements excessively burdensome and stressful. Over time and in combination, the personal and in some senses private inclination and capacity of individual GPs to do institutional work on all these fronts – to learn, complain or reluctantly comply – plays a central part in the social construction of the informal institutions of appraisal.

Importantly, those personal and private inclinations will change over time and in reaction to the broader experience of working as a GP in the NHS. So while the balance of logics may have settled in a relatively favourable position in 2008, increases in the bureaucratic burden since then – not least in the form of revalidation – may now mean that more GPs are inclined to see the same institutions in bureaucratic terms. Although institutional arrangements like appraisal are in some respects designed as discrete reforms intended to fulfil specific purposes, they are experienced in – and owe their legitimacy to – broader contexts, such that a small addition to the bureaucratic burden may prompt a decisive change in an individual GPs estimation of the costs and benefits of staying in the profession.

References

- Allen, D. (2014) Lost in translation? 'Evidence' and the articulation of institutional logics in integrated care pathways: from positive to negative boundary object? *Sociology of health and illness*, 36, 6, 807-822.
- Barber, B. (1963) Some Problems in the Sociology of the Professions, *Daedalus*, 92, 4, 669-688.
- Beer, M. (1981) Performance Appraisal: Dilemmas and Possibilities, *Organizational Dynamics*, 9, 3, 24-36.
- Chief Medical Officer (2006) *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. London: Department of Health.
- Currie, G., Lockett, A., Finn, R., Martin, G. and Waring, J. (2012) Institutional Work to Maintain Professional Power: Recreating the Model of Medical Professionalism, *Organization Studies*, 33, 7, 937-962.
- Delbridge, R. and Edwards, T. (2013) Inhabiting Institutions: Critical Realist Refinements to Understanding Institutional Complexity and Change, *Organizations Studies*, 34, 7, 927-947.
- Dixon-Woods, M., Yeung, K. and Bosk, C. (2011) Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors, *Social Science and Medicine*, 73, 10: 1452 -1459.
- Dorado, S. (2005) Institutional Entrepreneurship, Partaking and Convening, *Organization Studies*, 26, 3, 385-414.
- Fielding, A.G. and Portwood, D. (1980) Professions and the State – Towards a typology of bureaucratic professions, *Sociological Review*, 28, 1, 23-53.
- Friedman, M. (1986) Economists and Economic Policy, *Economic Inquiry*, 24, 1, 1-10.

- Freidson, E. (1970) *Profession of Medicine: A sociology of applied knowledge*, Chicago: Chicago University Press.
- Freidson, E. (1984) The Changing Nature of Professional Control, *Annual Review of Sociology*, 10, 1, 1-20.
- Freidson, E. (2001) *Professionalism: The Third Logic*. Chicago: University of Chicago Press.
- Freidson E. and Rhea, B. (1963) Processes of control in the company of equals, *Social Problems*, 11, 2, 119-131.
- Gale, J (2012) Government reforms, performance management and the labour process: the case of officers in the UK probation service, *Work, Employment and Society*, 26, 5, 822 - 838.
- General Medical Council (2014) *The GMC Protocol for Making Revalidation Recommendations*, Manchester: GMC.
- Goodrick, E. and Reay, T. (2011) 'Constellations of Institutional logics: Changes in the Professional Work of Pharmacists', *Work and Occupations*, 38(3): 372-416.
- Gorman, E.H. and Sandefur, R.L. (2011) Golden Age, Quiescence and Revival: How the Sociology of the Professions Became the Study of Knowledge Based Work, *Work and Occupations*, 38, 2, 275-302.
- Greenhalgh, T. and Wong, G. (2011) Revalidation: a critical perspective, *British Journal of General Practice*, 61(584): 166-168.
- Greenwood, R., Suddaby, L. and Hinings, C.R. (2002) Theorizing change: The role of professional associations in the transformation of institutionalized fields, *Academy of Management Journal*, 45, 1, 58-80.
- Haug, M.R. (1975) The Deprofessionalization of Everyone, *Sociological Focus*, 83, 197-213.
- Haug, M.R (1988) A Re-Examination of the Hypothesis of Physician Deprofessionalization, *The Milbank Quarterly*, 66, 2, 48-56.

- Illich, I. (1977) *Limits to Medicine, Medical Nemesis: The Expropriation of Health*, Harmondsworth: Penguin.
- Johnson, T.J. (1972) *Professions and Power*, London: Macmillan.
- Larson, M.S. (1977) *The Rise of Professionalism: A Sociological Analysis*, Berkeley: CA: University of California Press.
- Larson, M.S. (1980) Proletarianization and Educated Labor, *Theory and Society*, 9, 1, 131-175.
- Lawrence, T., Suddaby, R. and Leca, B. (2011) Institutional work: Refocusing Institutional Studies of Organization, *Journal of Management Inquiry*, 20, 1, 52-58.
- Leicht, K., Walter, T. Sainsaulieu, I. and Davies, S. (2009) New Public Management and the New Professionalism across Nations and Contexts, *Current Sociology*, 57, 4, 581-605.
- MacBride-Stewart, S. (2013) The effort to control time in the 'new' general practice, *Sociology of Health and Illness*, 35, 4, 560-574.
- March, J.G. and Olsen, J.P (1996) Institutional Perspectives on Political Institutions, *Governance*, 9, 3, 247-264.
- Murphy, K. R., and Cleveland, J. (1995) *Understanding performance appraisal: Social, organizational, and goalbased perspectives*. Thousand Oaks, CA: Sage.
- Muzio, D., Brock, D.M. and Suddaby, R. (2013) Professions and Institutional Change: Towards an Institutional Sociology of the professions, *Journal of Management Studies*, 50, 5, 699-721.
- Numerato, D., Salvatore, D. and Fattore, G. (2012) The impact of management on medical professionalism: a review, *Sociology of Health and Illness*, 34, 4, 626-644.
- Parsons, T. (1939) The Professions and Social Structure, *Social Forces*, 17, 4, 457-467.
- Perkmann M. and Spicer A. (2008) How are management fashions institutionalized? The role of institutional work, *Human Relations*, 61, 6, 811-844.

- Pellegrino, E D (1989) Character, virtue and self-interest in the ethics of the professions, *Journal of Contemporary Health Law and Policy*, 5, 53-73.
- Powell, W.W. and Colyvas, J.A. (2008) 'Microfoundations of Institutional Theory'. In Greenwood, R., Oliver, C., Sahlin, K. and Suddaby, R. (eds) *Organizational Institutionalism*. London: Sage. pp. 276-298.
- Preece, R. and Shah, N. (2010) *Appraiser Handbook*. Cardiff: Cardiff University.
- Ritzer, G. (1975) Professionalization, Bureaucratization and Rationalization: The Views of Max Weber, *Social Forces*, 53, 4, 627-634.
- Smets, M. and Jarzabkowski, P. (2013) Reconstructing institutional complexity in practice: A relational model of institutional work and complexity, *Human Relations*, 66, 10, 1279-1309.
- Spector, P.E. (2006) Method Variance in Organizational Research: Truth or Legend?, *Organizational Research Methods*, 9, 2, 221-232.
- Thornton P.H. and Ocasio W. (1999) Institutional Logics and the Historical Contingency of Power in Organizations: Executive Succession in the Higher Education Publishing Industry, 1958-1990, *American Journal of Sociology*, 105, 3, 801-843.
- West, M.A., Guthrie, J.P., Dawson, J.F., Borrill C.S. and Carter, M. (2006) Reducing Patient Mortality in Hospitals: The Role of Human Resource Management, *Journal of Organizational Behavior*, 27, 7, 983-1002.
- Waring, J., Dixon-Woods, M. and Yeung, K. (2010) Modernising medical regulation: where are we now?, *Journal of Health Organization and Management*, 24, 6, 540-555.
- Waring, J. and Bishop, S. (2013) McDonaldization or Commercial Re-stratification: Corporatization and multimodal organization of English doctors, *Social Science and Medicine*, 82, 147-155.
- Wilensky, H.L. (1964) The Professionalization of Everyone?, *American Journal of Sociology*, 70, 2, 137-158.

Wilmott, H. (1986) Organising the Profession: A Theoretical and Historical Examination of the Development of the Major Accountancy Bodies in the UK, *Accounting Organizations and Society*, 11, 6, 555-580.

Figure 1 Coding Frame

Logic	comments	% of coded words
For Society	Altruistic. Welcomes the opportunity provided by appraisal to reflect on and improve professional practice. Gives examples of personal and organisational learning and improvement prompted by appraisal.	50%
For State	Bureaucratic. Describes appraisal in terms of bureaucracy, politics, hoop jumping and dysfunction. Appraisal is represented as a political or managerial imposition which is a distortion of, and distraction from, good professional practice.	35%
For Self	Ego-centric. Largely transactional perspective in which appraisal is evaluated in the first person. Respondents question the personal benefits, complain about the time it takes and express resentment about the level of remuneration and loss of autonomy.	15%