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The McDonaldization of appraisal? Doctors' views of the early impacts of medical revalidation in the United Kingdom

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Abstract

Introduction: Medical regulation is rapidly changing with claims that systems such as revalidation/relicensing will reassure the public. Yet the impact of such initiatives is unknown.

Methods: Using the principles of efficiency, calculability, predictability and control through technology, identified by Ritzer, and exemplified by the McDonalds business model, we analyzed interviews with doctors between May 2012-Dec 2013 which focused on doctor experiences of appraisal and revalidation in SW England.

Results: The research found significant changes in appraisals since the launch of revalidation in December 2012. Appraisal has been standardized with a list of supporting information that must be collected by doctors. The success of implementation is measured in the numbers of appraisals completed but less is known about the quality of the appraisal itself. Such efficiencies have been supported by IT systems that themselves might be at risk of driving the process.

Discussion: There are potential advantages to McDonaldization including appraisals available to all, not just for doctors working in the NHS, and a potentially more appetizing recipe for their completion. As yet a state of *McAppraisal* has not been reached; with a complete transfer of trust in the doctor to trust in the appraisal process within revalidation. However policymakers will need to continue to ensure that regulatory initiatives, such as revalidation, are not just a process for their own sake.

Introduction

Since the 1980s commentators have been discussing the international trend towards the corporatization of healthcare (1-5) in which the traditional social organization of expert work (6) is being transformed by global models of bureaucracy and market logics that encourage rationalized and standard practices and identities (7).

As part of this wider process of corporatization, medical regulation too has undergone a significant transformation, with many countries implementing or preparing to implement new regulatory practices for professionals that engage with contemporary patient expectations and attitudes to 'risk' (8-11). Changes to professional regulation are emotive since they impact on the core identities of individuals as well as the profession as a whole (12).

For countries looking to implement changes to the regulation of their healthcare professionals, including doctors, it is important to re-engage with earlier debates about corporatization in the wider healthcare context and the theoretical frameworks through which they can be understood. This is because there is often an assumption that regulatory system will help to assure public trust in healthcare (13). For example, the General Medical Council (GMC), the United Kingdom (UK) professional regulator, state this explicitly as the driver for their own regulatory initiatives (14). However, assuming that implementing such initiatives will naturally led to greater trust cannot be taken as a given (15).

Medical revalidation was implemented in the UK in December 2012 following protracted debates (16). The exact drivers are controversial with some arguing that this was an internally driven response by the profession to a global change in public attitudes around professional autonomy, while others claim that the GMC were forced into the move (or at least forced into actually implementing a long debated initiative) after a series of disasters in

healthcare; including the Children's heart scandal at Bristol Children's Hospital and Harold Shipman, the mass murdering general practitioner (17, 18). Whatever the driver(s), the policy marked a seismic shift as one commenter put it, from 'club governance to stakeholder regulation' (8), and it stands out in terms of its scope especially in comparison to the rest of Europe (19). The central model requires practicing doctors to provide supporting information at an annual appraisal to demonstrate that they are "up-to-date and fit-to-practice". In this context, appraisal requires a doctor to meet with (usually) one appraiser, who is a medical colleague who might be from any specialty, department or practice. The appraiser has been trained and works with the doctor to help them reflect on their supporting information, such as patient feedback, complaints, audit. The output summary of each appraisal is then submitted locally – usually to the most senior doctor – known as a responsible officer (RO). In general, every five years the RO makes a recommendation to the GMC, who either revalidates, defers the decision (for example due to inadequate information following a career break) or works with the doctor if they fail to engage through not submitting supporting information or refusing to conduct an annual appraisal. Importantly medical revalidation has been built on top of existing appraisal systems, at least in the National Health Service (NHS), where all senior doctors have been expected to engage in annual appraisal, developed and delivered by their NHS employer, since 2002 (20).

Original research, undertaken as medical revalidation was initially rolled out, aimed to understand the impact of medical revalidation in practice (21). It was hypothesized, that with ongoing policy concerns (16), there would likely be unintended as well as intended consequences of its implementation. It was hoped that by learning from the practical experiences of doctors, there would be opportunities to identify areas for improvement as the program becomes embedded.

The aim of this paper is to describe our original data arising from a study into appraisal, as revalidation was being launched, through the lens of Ritzer's contested but highly influential McDonaldization thesis (22). The thesis used the McDonald's business model to critique a wide range of processes that exhibit the organization and standardization of activity for efficiency. We undertook this as Ritzer's thesis appeared to deductively help us to understand our original thematic findings. While Ritzer's thesis has been used both explicitly (7) and implicitly (5) in healthcare, we are the first, in the UK context, to draw on this important theoretical lens to help better understand the impact of a major healthcare regulatory policy.

Methods

Between May 2012-Dec 2013, we approached all ROs initially in the county of Cornwall where a medical revalidation pilot had recently been completed, and then in Plymouth, Devon, in the South West of the UK. We asked for their help in recruiting doctors who might consent in having their appraisal video-ed and then being interviewed shortly thereafter. Where possible we sought to interview both doctors involved in each appraisal, as the appraisee and appraiser. We drew on the videoed appraisals to develop a series of individualized 'prompt questions' for semi-structured interviews to facilitate focused recall on participants' actual lived experience. This was achieved by direct review of the videoed appraisals to identify illustrative examples of areas we wished to explore. These were then mapped, in discussion with the research team, to our generic questions which had been drafted from earlier research (16). Sample questions included: what works well for you in appraisal [...what do you think about this section in your appraisal where you discuss...?]; what doesn't work well; does anything need to change to make appraisal better; does appraisal need to change to make appraisal better for revalidation; what do you think the

purpose of revalidation is; and in what practical ways is appraisal supported in your institution?

Ethical approval was secured through the NHS National Research Ethics Service (REC: 11/SW/0112) and local R&D permissions were agreed through the separate Trusts.

In total, twenty-four semi-structured interviews were recorded (by SN and JA) across primary, secondary and community care: with thirteen doctors as appraisees; five appraisers; four ROs; one GMC Employer Liaison Advisor (ELA), who is employed to support ROs in each geographical region; and one primary care systems manager involved in supporting revalidation implementation. Six appraisal videos were also captured. Data saturation was reached at this point with no further new themes emerging following initial coding. It was also felt that there was appropriate representation across the main healthcare settings and the appraisal/revalidation system to capture a broad and inclusive view.

Interviews were transcribed and then coded using NVivo 9 qualitative data analysis software (QSR International Pty Ltd. Version 9, 2010) by SN, in discussion with the rest of the research team, including negotiation of any differences of opinion. We used a ‘holistic coding’ method in the first instance in order “to ‘chunk’ the text into broad topic areas, as a first step to seeing what is there” (p.67) (23). Initial analysis identified eleven main themes: appraisal and revalidation; attitudes; challenges; history; identity; people; pilots; politics; processes; and system. All underlying themes and their sub-themes are summarized in Table 1.

Insert Table 1 here

During this analysis, while exploring possible superordinate themes, we identified a possible overarching theoretical perspective that helped us to better understand the dominance of organization and standardization of activity for efficiency within the narrative of our participants. This perspective was Ritzer’s thesis on McDonaldization. Ritzer’s

McDonaldization is characterized by four key components; efficiency, predictability, calculability and control through (what he termed) 'non-human' technology (22). By examining our interview data in these terms any areas of appraisal practice could be deductively identified that spoke to Ritzer's characterization.

Results

We found that the majority of our data mapped onto Ritzer's four key components of efficiency, predictability, calculability and control through technology. This mapping exercise, conducted by SN and supported by the other authors, is summarized in Table 1. Where our codes did not explicitly map over, they referred mainly to: attitudes and language; or the peoples and communities involved. These codes were therefore mainly about existing structures and changing attitudes as revalidation was being launched on the back of established appraisal systems in the NHS. So, while they did not explicitly map to Ritzer's definitions these codes were part of the overall landscape that recognized significant change to practices and associated rhetoric.

Participants in the research overwhelmingly considered their annual appraisal to be an extremely valuable formative process. However, as appraisal becomes linked to revalidation, and therefore has a summative function, many of them expressed concerns that revalidation could become a driver for appraisal and the formative nature of appraisal would change as a result.

Done properly appraisal can provide feedback on performance, stimulate staff development and engender motivation (24). However, in the videos of appraisals, and as doctors recognized, there was significant variation in the form and content of appraisal. For example, doctors brought their own personalized data from their practice, despite the required supporting information for appraisal in revalidation being clearly pre-defined by the GMC,

and different appraisers focused on different aspects of the process; some more on pastoral aspects, others on quantity of submitted data in the doctors' portfolio. The doctors' main concern leading on from this was the potential for any rationalization of appraisal, for the purposes of revalidation, to turn appraisal either into a 'tick box' exercise or an unwieldy bureaucratic system; in extremis detracting doctors from the very medical practice revalidation is meant to support. Thirteen interviewees used the tick-box analogy mirroring the language identified during consultant interviews on the introduction of the consultant appraisal undertaken in 2007 by McGivern et al. (25).

In typical examples, from two appraisees:

It depends on how creative and human the appraisers are going to be; if they're going to be box ticking bureaucrats then yes, we'll have lost a valuable method of formative education. **1PCAEEF7**

I think the direction is towards tick-boxing and I feel really sad about that, because I was someone who was appraised and did appraisal and I thought that this was a really useful process. **1PCAEEF5**

Efficiency

The first principle: Efficiency, is defined by Ritzer as the optimum means to a given end. Key features of which are streamlining and simplifying. Efficiency in this context relies on a pre-designed process governed by organizational rules and regulations. Linking revalidation to the extant, and broadly popular, appraisal process obviated the need for an entirely separate system to be developed. Thus, in theory doctors would be saved the time of undertaking a separate process and organizations the expense of implementing one.

In order to answer the requirements of revalidation the portfolio of evidence presented for appraisal has undergone a process of simplification and streamlining. Like the

McDonald's menu, the appraisal portfolio is limited, with the form and content of its component parts determined by the four domains of the GMC appraisal structure: General information; Keeping up to date; Review of practice; Feedback on practice (26). The elements of the portfolio that informs appraisal have now been similarly rationalized: with six types of supporting information that doctors are expected to provide and discuss in their appraisal at least once in each five-year cycle: continuing professional development; quality improvement activity such as audit; significant events; feedback from colleagues and patients: and review of complaints and compliments (27).

In the old days, people could put all sorts of evidence in, now the guidance implies that you only need certain – it's like the minute you have a tick box, people stop putting in the more interesting things. Yeah, I think the risk is that people will just do the minimum. **1PCAEEF6**

The preference for online submission streamlines the processes for appraisees, appraisers and ROs alike. Scotland has a 'one-stop' Scottish Online Appraisal Resource (SOAR), as does Wales with their Medical Appraisal & Revalidation System (MARS) although in England there is more flexibility. One interviewee tasked with overseeing systems to support revalidation in primary care identified the need for and, later on in the interview, the expense of external provision:

We had a go at our internal IT systems having a go, and developers having a go at making a bespoke system for us, um but when you look at the cost of those things there would certainly be a need for more server space and training and things of that nature but we were just not geared up to do that and the skills of the team weren't in place in order to do that so going to an outside company seemed the better option.

1PCAEEF5

Another aspect of efficiency identified by Ritzer was ‘putting the customers to work’, (for example customers clearing their own trays in fast food outlets, self-check in at the airport and self-checkout at the supermarket). In medical appraisal it is the appraisee who has to collate and present the evidence for the appraisal. The GMC ELO we interviewed clearly identified that responsibility lay with the doctor:

I think something that is really key and a lot of the time gets overlooked is actually it’s on the individual doctor, you know they are a professional, they are in a privileged profession and they have to take responsibility for their own revalidation ... make sure they’re engaging in appraisal, doing their CPD, gathering patient and colleague feedback, and actually learning from those experiences and taking that forward over a period of time. ... it’s ultimately their responsibility to keep the privilege of being on the register. **GMCELOM1**

ROs, appraisers and appraisees stated that they found this difficult with the healthcare systems not being geared up to provide the information required for annual appraisal. In a typical example:

I mean things are being tightened up but still in this Trust I don’t get any Trust-generated data about me for my appraisal, nothing at all, so everything I bring to my appraisal I have to source. **0SCAERSF1**

Predictability

Predictability relates to discipline, systematization and routine. Just as a McDonalds burger is guaranteed to be as ‘appetizing’ in one place as it is in another, patients should be assured that their doctor is up to date and fit to practice in wherever and whatever context that might be. Predictability provides the assurance that revalidation is a standardized process

expected to capture relevant and similar information across all medical fields at regular intervals.

The requirement that appraisal and revalidation are undertaken regularly requires a review of the often haphazard appraisal timetable. The research often found appraisals cancelled at a moment's notice and others slotted in as opportunities, or more commonly, other deadlines arose.

With one appraiser for 3 years appraisees will have some continuity, and with standard portfolio components longitudinal trends can be identified. The primary care systems manager interviewed, cited the logistics of a paper system in the dispersed geography of Devon and Cornwall as a barrier to anything other than an electronic system.

Well the beauty of the system we've chosen is that no matter where you are in the country you could still input, you still have access to your folders and files and stuff, and also on transfer, so if somebody was going to change performance list and go and work in a different part of the country and stuff, ... the [software] company will actually facilitate the shifting between performance lists and things of that nature.

1PCSTMF1

The colleague and patient feedback elements have undergone reliability and validity testing to ensure that the optimum number of examples is submitted (28-30). But the requirement of patient feedback as supporting evidence for revalidation is proving a concern to doctors across the sector (31).

There are well worn arguments about the difficulty of gathering meaningful patient feedback from anaesthetists, radiologists and pathologists, but the research also found subtler concerns expressed linked to type of patient rather than medical specialty; for example, the elderly, patients with mental health issues and/or addiction. For one GP interviewed the

requirement that the doctor should not give out the feedback forms themselves presented challenges:

If somebody comes in who is intoxicated, which a lot of my patients are, or angry or maybe has learning difficulties or something like that they [the receptionists] just wouldn't give them a form. I am sure they do it like that. They wait until you're having a good day and everything is quiet and calm and then they give out the forms. So, it took them months to give out my forms and get them back. **1PACEEF6**

Calculability

Revalidation is an example of the internationally recognized trend that individuals and many areas of contemporary life are becoming subject to an increasing number of calculative regimes which seek to survey and performance manage their practices in order to better economize and risk manage them (32). In this quote from an RO is the suggestion that revalidation could impact on doctors' decision making:

If it became a hugely bureaucratic and unwieldy sort of endeavor, taking doctors away from looking after patients and pushing them towards hugely bureaucratic form-filling and tick-boxing I think that would be harmful to patients. Patients require professionals who are able to make difficult judgements in risky situations. And if bureaucratic systems stop them doing that out of fear, I think that would be harmful to patients. **0SCROM1**

This RO also discussed how revalidation had already made some surgeons risk averse.

...some who won't touch difficult cases with a barge pole. That's not good for patients, but it's good for their figures. **0SCROM1**

With calculability, the emphasis is on quantification rather than quality. One appraiser described the change in emphasis with the advent of revalidation:

I think it's becoming, there's getting to be more regulation and it's becoming less about you personally, more about the regulations, more about having all the bits of paper and it's no longer looking at your personal journey through those bits of paper, it's about just having those bits of paper there. **OPCAEER4**

In answer to the question 'So, do you feel that revalidation will contribute to the three key areas of patient safety outlined in the path-finder pilot report: effectiveness of care, patient experiences and patient safety? One RO interviewed replied:

I think it will do these things, but I don't know how you measure these things.... It may be that public interfaces, the way these things will be visible, but whether there will be sufficient data there to measure them. ... This is one of the challenges isn't it? looking at outcomes of interventions that we are doing. **OPCROM1**

Crucial to any discussion of calculability is the available technology and its ability to generate data and audit trails. We saw above, the system primary care in Devon and Cornwall were interested in being equated with 'beauty'.

Calculability is closely connected with the other factors of the business model. For example, it makes it easier to determine efficiency, and quantification is also linked to control. However, in the drive to quantify there is a risk that there will be no place for the soft skills and local knowledge that were identified as important by ROs, appraisers and appraisees alike.

Control through technology

The use of technology has been discussed in connection with all the elements so far. The participants were often skeptical about overreliance on 'non-human' technology:

But it would be a shame to lose that human element at the end of the day because one would think that that's actually a telling opportunity to actually see what's happening in real life. **0PCAEEF2**

One witnessed appraisal interview, that took place in front a computer screen, had a significant amount of its allotted time taken up in conversations with the system helpdesk as documents had failed to upload and could not be read by the appraiser. There was a sense of mounting frustration as the appraisal progressed and after 20 mins they reverted to a paper form. Several interviewees expressed annoyance that systems changed from one year to the next and one appraisee intimated that issues of IT system confidentiality would impact on the content of the appraisal.

Nobody can guarantee to me that everything that goes on an electronic site is confidential ... we've moved from an appraisal which is a meeting between you and your appraiser to revalidation where somebody else has to have a view to recommend you for revalidation and there are some things, there was in that [appraisal] interview, where I'm happy to show my appraiser but I would not be happy to put on an electronic site for who knows to see, because it's confidential. **1SCAEESF2**

Indeed, several interviewees identified the opportunity to hide information with doctors selecting their own evidence: potentially information that would have been discussed in the old system of appraisal prior to the introduction of revalidation.

Discussion

Underpinning his thesis with the classical sociological writings of Max Weber on bureaucracy and rational systems in the early 1900s, Ritzer used the McDonald's business model as a paradigm through which to critique a wide range of processes that exhibit the organization and standardization of activity for efficiency. The 4 key components of

McDonaldization (Efficiency, Predictability, Calculability and Control through 'non-human' technology) in combination make up the type of rational system that Weber would have recognized.

Weber considered rational systems to be technically superior to all other forms of administration. Yet he was aware of the potentially dystopian aspect through the concept of the 'iron cage of rationality' where bureaucracy traps and dehumanizes people making them 'cogs in the wheel' of society (33). Weber recognized that rational systems inevitably spawn irrationalities as unintended consequences.

Already there is a sense that certain doctors or groups of doctors will be creative in the way they collect and present data for appraisal. Ritzer argues that rational systems are unreasonable systems because they end up determining the work of the people who work within them. Potentially doctors could work for revalidation in the way that some teachers 'teach to the test'. So as medical regulation inevitably evolves along 'scientific bureaucratic' trajectories (34), getting the 'test' right is central to policy development. There has been criticism of a lack of clear purpose for revalidation, with questions raised about if it is to identify poor doctors, drive up standards or attempting to achieve both (16). This lack of clear purpose matters if doctors are likely to work to 'pass' whatever is presented to them, reacting adversely to any uncertainty with potentially damaging skepticism (35). Calculability is also linked to irrationality because the emphasis on quantity tends to affect quality adversely. The GMC publish the numbers of doctors who have undergone revalidation on their website and assess that against the target dates. (36) The quality of those appraisals is not part of that reporting, although is being addressed elsewhere, (37) but as we witnessed in our sample, and has been verified more recently, (38) there is enormous variety between appraisals. This has also been raised as an area of concern in a recent major review of medical revalidation; with

the report's author, Sir Keith Pearson, commenting that there is "limited assurance around the quality of those appraisals"p23 (39).

It is important to recognize though that Ritzer is keen to point out that there are many advantages to McDonaldization. In the case of revalidation these would include a system of regulation that applies to all doctors, not just those working within the NHS, a system that will ensure a predictable process that will accommodate locum doctors and outliers by assigning them an RO, and it will provide the public with the assurance that doctors like other professionals undergo a formal process.

Ritzer's main criticism of the McDonalds model is its potential to become de-humanizing when the focus is on efficiency, predictability and calculability. He argues that the drive for efficiency means that the world may not be organized for the benefit of consumers (the doctors undergoing revalidation and ultimately their patients) but for the benefit of the organizations who need to demonstrate efficiency to the outside world; "for the sake of political pragmatic exigency" p.1 (40). The doctors interviewed for this study were particularly worried that if revalidation were stripped down to a 'tick-box' exercise it would in fact undermine them professionally as it would be meaningless.

If revalidation drives 'hard' data collection and systems, the prevailing medical positivistic model, this could be at the expense of 'soft' data – leading to a risk that practice could become decontextualized. In a recent large survey of the profession, 30% of responding doctors felt that medical revalidation had had a negative impact on the appraisal process. (38) There is an attendant risk that the important pastoral element of appraisal could be lost either due to the requirements of revalidation or participants being less willing to share any issues which doctors would likely benefit most from discussing and receiving advice on. If so, revalidation cannot only be dehumanizing, but also misses an opportunity to address problems. This would be a manifestation of the dehumanizing potential of rational systems,

when paradoxically there is evidence that to achieve desired behavioral change it is the very nature of ‘the personal’ within appraisals, two people coming together to reflect on data, that helps to accomplish positive action (41, 42).

One approach might be to relax the one size fits all model allowing doctors to bring more of what they want from their own practice. This would move away from the efficiencies of scale and reduce predictability but it might allow doctors to feel ownership of their data about their practice. This could be undertaken at specialty level – not necessary at an individual level – as after all McDonalds products vary from region to region as local tastes in sugar and salt levels differ.

Central to supporting the medical profession with behavioral change, and therefore assumed betterment of patients, is the mentoring and support from the role of appraisers (42). While this is an expensive component, and hard to standardize, the literature is clear that external, trusted data facilitated over time by a trained individual is fundamental to bringing about positive change (43).

Ritzer concludes his thesis with a challenge. In the face of relentless McDonaldization, he forces us to reflect on how we should decide which forms of McDonaldization are positive and which are destructive; in order to conclude –what sort of alternatives we might need. We would argue that future policy developments should focus on the central relationship of appraisal; so that all innovations in standardization, efficiency, predictability and technological offers consider how they will support or hinder the appraisal relationship.

A limitation of the study for this type of analysis was that it took place early in the implementation of medical revalidation and it drew participants from a restricted geographical area. The doctors interviewed were from primary, secondary and community Trusts (healthcare employers) but none of these were locums or doctors in private practice.

However, Cornwall had been one of the pilot areas, so had some experience of the process, whereas Devon and Plymouth had not. Linking this with the wider literature, including the recent Pearson review which reports that “the process feels burdensome and ineffective to some doctors” p.27 (39), indicates that our findings are likely to be broadly generalizable.

Conclusion

So does revalidation signal the McDonaldization of appraisal? The answer to this question would be not at present. We will only have reached a state of *McAppraisal* when there is a complete transfer of trust in the doctor to trust in medical revalidation through the appraisal process. However, this paper has usefully applied Ritzer’s McDonaldization thesis as an analytical framework to highlight some cause for concern as the process is rolled out and provides empirical evidence to support the claims and concerns of others (13, 15, 44). While this research took place in the UK, based on interviews with doctors, it provides some important reflections for health policy internationally. This includes that policymakers will need to continue to ensure that medical regulation initiatives, such as revalidation informed by appraisal, are not just processes for their own sake but are focused on and can ultimately be evidenced to benefit patient care.

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