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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 exampled 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.
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1. 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 Chil-

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dren'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.

2. 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 to 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.

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.

3. 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 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

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