Portfolio-Based Performance Appraisal for Doctors: A Case of Paperwork Compliance

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Abstract

This paper discusses the findings of research exploring the conduct of portfolio-based performance appraisal within medicine. Portfolios are now used throughout medical school and junior doctor training, in later specialist training, as well as to support the implementation of annual NHS appraisal of doctors as part of their employment contract. They will also play a role in the new medical governance quality assurance process known as revalidation, when it is implemented in 2010. The paper discusses how the growth of portfolio-based performance appraisal within medicine is bound up with the growth of managerial systems of surveillance and control within western health care systems. Theoretically, it draws upon a Governmentality perspective to analyse doctor's accounts of the appraisal process. This views appraisal as an information panopticon that to better enable social control seeks to construct appraisees as calculable and administrable subjects. However, the paper highlights how the doctors interviewed used the tacit dimensions of their expertise to engage in creative game-playing toward appraisal, adopting a stance of paperwork compliance toward it. Paperwork compliance leaves a paper trail that makes it appear doctors have complied with the technical requirements of performance appraisal when in fact they have not. The paper concludes that current reforms to medical governance introduced to ensure the general public is protected from medical error and malpractice, provide sociologists with an invaluable opportunity to undertake a dedicated research program into the performance management of medical work.

Keywords: Annual Appraisal, Audit Society,, Governmentality, Medical Autonomy, Medical Regulation, Paperwork Compliance, Performance Appraisal, Revalidation

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Portfolio-based Performance Appraisal within Medicine

1.1 This paper reports the results of research undertaken to investigate the conduct of portfolio-based performance appraisal within the medical profession in the United Kingdom. Many things are called portfolios including logbooks of activity, observational check lists, records of critical incidents and collections of personal reflective narratives (Redman 1995). In line with vocational and professional education in general a portfolio is typically defined within medicine as a *'dossier of evidence collected over time that demonstrate a doctor's education and practice achievements'* (Wilkinson et al 2002: 371).

1.2 Paper-based and electronic portfolios are now used throughout medical school and junior doctor training, in later specialist training, as well as to support the implementation of annual appraisal of doctors as part of their National Health Service (NHS) contract (Snadden 1998, Wilkinson et al 2002). They will also play a role in the new medical regulatory quality assurance process known as revalidation when it finally 'goes live' from late 2010 onwards (Donaldson 2008). Revalidation involves a rigorous 'hands on' assessment of a doctor's continued fitness to practice. It has been introduced as a result of a series of high profile medical malpractice cases, including the general practitioner and serial killer from Hyde in Manchester, Dr Harold Shipman, who was convicted of killing 215 of his patients (Chamberlain 2009a).

1.3 The introduction of portfolio-based performance appraisal within medicine presents a significant development in the governance of doctors and the regulation of medical expertise within the NHS (Chamberlain 2009b). Over the last three decades sociologists have recognised that medical practitioners' traditional autonomy over their work and the standards governing it has increasingly become subject to risk adverse management-led systems of performance management and clinical governance (Ahmad and Harrison 2000, Gray and Harrison 2004). But it is also acknowledged that conceptual and theoretical

consideration of the growth of performance appraisal policy and practice and its impact upon medical autonomy suffers from a lack of substantive empirical data (Friedson 2001, Kuhlmann and Saks 2008). The research findings discussed in this paper therefore possess particular relevance to analysts concerned with contemporary developments in the regulation of doctors and provision of health care services. Not least of all because they represent the first attempt to capture rank and file medical practitioner's own experiences and perceptions of key reforms in the surveillance and quality assurance of their continued fitness to practice.

Appraisal as Information Panopticon: Governmentality in the Audit Society

2.1 As noted in the previous section, it can be argued that the introduction of portfolio-based performance appraisal for doctors is just one more example of the internationally recognised trend that, like many other professionals, doctors are becoming subject to a seemingly ever increasing number of formal calculative regimes which seek to performance manage their work practices in order to better economise and risk manage occupational tasks (Coburn and Willis 2000, Checkland et al 2007, McDonald et al 2008). Power (1997) emphasises the enormous impact of the contemporary trend in all spheres of western societies toward Audit in all its guises - with its economic concern with transparent accountability and standardisation - particularly for judging the activities of experts. This is bound up with the re-emergence of liberalism as an economic and political philosophy (Rose 1996). Against this background Townley (1993a 1993b), Newton and Findley (1996) and Rose (2000) all suggest performance appraisal (portfolio-based or otherwise) is a distinctive form of neo-liberal Governmentality ? a system of control which utilises surveillance and rationality to turn the object of its gaze into a calculable and administrable subject open to control and risk management (Foucault 1991).

2.2 This Foucauldian interpretation of appraisal holds that it acts as an 'information panopticon' that operates through the use of two key panoptic disciplinary mechanisms ? normalisation and hierarchy (Zuboff 1988). Normalisation, or normalising judgments, involves comparing, differentiating and homogenizing in relation to assumed norms or standards of what is proper, reasonable, desirable and efficient (Foucault 1977). Appraisal possesses normalising judgements due to its focus upon establishing behavioural norms in the form of 'on the job' task standards from which to judge individual performance. Hierarchy involves a process of judging, ranking and rating an individual without in turn being judged (Foucault 1977). This reinforces that no matter how much its advocates hold it is user-centred and developmental performance appraisal is nevertheless a punitive disciplinary tool concerned with identifying areas of under-performance and correcting them (Fletcher 1997).

2.3 Yet appraisal is not a straightforward punitive disciplinary tool, concerned with identifying and correcting poor performance 'from the outside' (Rose 1996). Indeed, the Foucauldian interpretation of appraisal holds that it may seek to promote and reward certain behaviours and rectify others, but it recognises that it nevertheless more often than not does so by operating using a more subtle and invasive form of soft power (Rose 2000). Certainly within medicine appraisal seeks to work on the subjectivity of appraisees 'at a distance' through requiring they engage in self-surveillance of their clinical performance as if it were a normal and everyday practice as a result of the availability of best-evidenced clinical guidelines and protocols (Sheaff et al 2003). For example, for annual NHS appraisal consultants and general practitioners must keep a portfolio of their continuing professional development needs and fitness to practice which contains personalised information relating to prescribing patterns, the outcomes of case note analysis, the results of clinical audit, as well as patient complaint case outcomes and surgical operation success rates (Black 2002). They must use this information to help identify and publicly record areas of developmental need in relation to best-practice performance frameworks, guidelines and protocols (Bruce 2007). Furthermore, they must subsequently record activities and achievements that demonstrate they are proactively meeting their 'self identified' learning goals, which will subsequently be subject to formal peer review, to prove they are willing as a matter of good professionalism to admit to areas of poor performance and learn from them (Irvine 2003). It will perhaps come as no great surprise then to learn then that individuals who advocate portfolio-based performance appraisal within medicine argue that it simply formalises what should already be a normal and natural part of a doctor's day to day self-monitoring of their clinical performance (see Snadden and Thomas 1998, Davis et al 2001 and Wilkinson et al 2002). Consequently this paper holds the growing use of portfolio-based appraisal within medicine provides an invaluable opportunity to examine contemporary reforms in the performance management of medical work.

Research Aims and Methods

3.1 The following research question was proposed to guide investigation:

> *What are the perceptions of doctors involved in supervising and assessing medical students and junior doctors during workplace clinical placements concerning the recent introduction of portfolio-based performance appraisal within medicine; both for them as part of their NHS contract and for medical trainees during clinical training placements?*

3.2 The conduct of the research was determined by the British Sociological Association guidelines on good ethical practice (see http://www.britsoc.co.uk). To protect their right to anonymity study participants have been given pseudonyms, while the location the study took place in is referred to as Blue Town and its medical school as Blue School. In order to answer the research question a research sample population had to be defined theoretically, on the basis that to be included a doctor in Blue Town had to be subject to annual appraisal as part of their NHS employment contract and therefore was either a consultant or general practitioner. They also had to be involved in supervising and assessing medical students and junior doctors during their clinical training placements and so had to have used a trainee's portfolio to track and assess their progress. 189 doctors in the Blue Town area are involved in supervising and assessing medical students and junior doctors during clinical placements. Each was contacted and asked if they would agree to participate in the research. 103 did.

3.3 Good research practice dictates that data typically needs to be collected from between 30 and 50 interviewees before data saturation is reached with emergent themes fully explored and generalisable to comparable settings (Bryman 2006). 46 doctors from a range of specialities were interviewed (see Table 1). Interviews ranged between 45 and 90 minutes in length. All 46 interviews were tape-recorded, transcribed in full and securely stored. Although initially selected on the basis of their gender, age, ethnicity and medical speciality, interviewees were increasingly selected at random from the list of volunteers as key themes emerged over time and these variables were discounted as core explanatory factors concerning the conduct of appraisal.

3.4 Throughout the data collection and analysis process the author deliberately sought to disprove his developing understanding of the conduct of appraisal using respondent validation by framing interview questions in such a way that informants used their own personal experience to answer them in a either a positive, 'supporting', or negative, 'disproving', sense. To further ensure the reliability of interpretation and enhance analysis a critical friend reviewed transcripts after all identifying elements had been removed, cross checking and discussing coding with the author to further authenticate his analysis. This process proved invaluable in the final stage of analysis as emergent themes were fully saturated (i.e. no new or contradictory data was collected) and linked to an explanatory core theme or central storyline, which as the paper will discuss in due course was defined as paperwork compliance (Strauss and Corbin 1990).

3.5 Data triangulation between informant accounts, alongside the use of a third party to verify the author's interpretation of them, does enable biases such as the self-selecting nature of the research sample to be in part accounted for (Strauss and Corbin 1990, Bryman 2006). The paper therefore argues the research has generated a conceptual tool - paperwork compliance - which at the very least can act as a useful heuristic sensitising device for others to utilise when analysing the application of portfolio-based performance appraisal in other contexts. But at the same time it acknowledges that more research with trainees (for trainee appraisal) and appraisers (for annual appraisal) is needed to further verify the research findings presented here.

Research Findings

4.1 The research was concerned with exploring doctor's experience of portfolio-based performance appraisal within two contexts. First, for them as NHS employees subject to portfolio-based performance appraisal as part of their employment contract i.e. annual NHS appraisal. Second, for them as clinical placement supervisors who must conduct portfolio-based performance appraisal on medical trainees (medical students and junior doctors) as they progress through training requirements. The research sought to identify key features present across both contexts of its application, through exploring with interviewees their experience of the process of performance appraisal for themselves and trainees. It is important to note that regardless of the nature of expected portfolio content (i.e. compare medical trainee to senior doctor) or the context of application (i.e. compare junior hospital doctor to general practitioner) the appraisal process requires individuals identify their learning needs, set learning goals in light of these, and subsequently record activities and achievements for later review by an appraiser (Challis 1999). Furthermore, regardless of the context of its application or the nature of expected portfolio content, within medicine the performance appraisal process demands compliance with NHS managerial and clinical governance imperatives through requiring appraisee's internalise and make personally meaningful in their day to day work activity nationally-set practice standards i.e. best-evidenced clinical protocols and guidelines (Wilkinson et al 2002).

A Lack of Time, Training and Follow Up

4.2 From talking to interviewees it was clear that three inter-related contextual factors seemed to influence the conduct of appraisal ? time, training and follow up. It has long been recognised that for many doctors, working on a busy hospital ward means educational tasks frequently must take second place behind day to day clinical duties and priorities (Gray and Harrison 2004). Interviewees certainly felt they had little time to complete appraisal requirements in the prescribed manner and that annual NHS appraisal in particular had been introduced without adequate consideration of the time pressures they were under. As Dr Lamb noted, appraisal *'takes a lot of time to complete if you are going to do it properly? and time is a short commodity around here.'*

4.3 Historically there has been a cultural tendency within medicine to equate clinical expertise with the ability to teach (Irvine 2003). But portfolio-based performance appraisal brings with it certain procedural and technical requirements, so it might therefore be expected that interviewees would have completed some form of training program. Yet no interviewee had received formal training in trainee appraisal. Furthermore interviewees accounts of the management of annual NHS appraisal showed that their appraisers by and large lacked the knowledge and skills necessary to manage the process neutrally, efficiency and effectively. For instance Dr Brown held that *'your appraisal very much depends upon your relationship with your clinical director, if that's generally good on a day to day level then your actual appraisal meeting usually lasts for as long as it needs to complete and sign all the forms.'*

4.4 Interviewees also stressed that in their personal experience annual NHS appraisal lacked 'follow up', failing to deliver on its promise to improve doctors working conditions. For example, Dr Philips argued that appraisal *'does give you an opportunity to step back and look at the work you do and what problems you face doing your job on a day to day basis. Like in terms of its management, in terms of organising things like clinical and secretarial support in order to operate effectively. But the problem is that when things are highlighted, and it is agreed that changes need to be made For instance, it was agreed in my last appraisal that we needed another medical secretary in the department. But here we are still waiting for that to happen eight months later.'*

4.5 Whatever failings they feel appraisal possesses, it would be expected that their sense of professionalism would demand a doctor engage with the process in spite of what they feel its current problems and limitations are. After all, fundamentally portfolio-based appraisal is about promoting good professional practice. It publicly records a practitioner's willingness to place their patient's needs and interests above their own through being critically reflective of their clinical performance and where necessary admitting to mistakes and learning from them (Wilkinson 2002). However when questioned further about the role portfolio-based appraisal played in identifying poorly performing doctors, interviewees would typically remark that poor performance would be detected by clinical colleagues '*at the day to day level on the ward, not in an appraisal meeting'* and therefore would be dealt with *'outside of the appraisal system'* (Dr Philips)**.** Similarly, in the context of trainee appraisal, interviewees argued for the need to *'focus on assessing them (trainees) actually doing the job, instead of focusing on the appraisal paperwork'* (Dr Rose).

4.6 All forty-six interviewees remarked that appraisal for themselves and trainees tended to be conducted somewhat ritualistically. They preferred to assess trainees 'on the job' and argued poor performance (both their own and trainees) would be detected and dealt with off the record. It was clear that appraisal was largely viewed and completed by clinicians as a paper exercise. For example Dr Grading argued that: *'in general they are more pieces of paper flying around these days. But I think there is a general kind of automation to filling in forms. You see you are going in, doing this and doing that, filling out this and filling out that, and not because you want to but because you have to. So I am not sure how much is actually being done how the medical school or whoever wishes really.'* This preference for dealing with underperformance outside of the formal appraisal process could be said to be due to respondents recognising that a completed portfolio can act as an auditable career record. Here even one negative report could possess long-term consequences for an individual's career. There certainly was an understandable eagerness to give trainees in particular the benefit of the doubt when mistakes occurred, as well as to generally deal with problems via *'less formal channels then the appraisal process unless absolutely necessary'* (Dr Redmond).

Non-compliers, Minimalists and Enthusiasts

4.7 Doctor's accounts revealed that contextual factors, such as a lack of training in how to conduct trainee appraisal, influenced the conduct of portfolio-based performance appraisal. However, this should not be taken to mean that all research respondents responded negatively to it. Indeed, six of the forty-six interviewees viewed annual NHS appraisal positively. Arguing that in spite of its current problems and limitations, or how their appraiser handled the appraisal process, a personal commitment to making it work for them no matter what, had helped them use it to identify how they are doing in their job as well as decide what the next steps in their career should be.

4.8 Similarly, interviewees were not wholly negative about trainee appraisal. It being possible to identify three different attitudes toward trainee appraisal. First and most dominant were the 'non-compliers' (nineteen out of forty-six interviewees). These individuals may be passionate about their medical specialty and the supervision of trainees, but they nevertheless said that they ignored a trainee's portfolio when assessing them. Frequently, but not always, they would use factors such as having a lack of time to justify their non-compliance. But regardless of if they focused on such matters or not, non-compliers all preferred to do things their own way and 'sign off' a trainee's portfolio documentation at the end of the placement: *'I don't tend to look at their portfolios really. There really is no need for me to do that past scanning it to make sure all the boxes have been ticked and the right pieces of paper completed and signed at the end of the placement...When they (a trainee) turn up on day one I tell them what I expect of them and will be looking out for, and I tend to just fill in the portfolio paperwork around those expectations of them'* (Dr Grade).

4.9 'Minimalists' (seventeen out of forty six interviewees) reported that they held some albeit highly informal and often irregular one to one meetings with students to check on their progress. Unlike their non-complier counterparts who only saw a trainee's portfolio at the end of a placement, they had some minimal contact with a trainee's portfolio during a clinical placement. Minimalists reported that having this minimal contact helped them check on an ongoing basis that the paperwork was up to date. This they felt made its completion an easier task: *'I do try to arrange things so that we meet and record what is happening in the portfolio as I think it is important to keep a record of their progress as they go along...I find that approach is liked by students as it makes them feel that you are keeping an helpful eye on them. It certainly makes checking and completing portfolio documentation less of an onerous task than it is when you try to do everything all at once at the end'* (Dr Yellowhouse).

4.10 Like minimalists, 'enthusiasts' (ten out of forty six interviewees) held meetings with trainees during a clinical placement. However, with enthusiasts these were more formally planned to take place at the beginning, the middle and the end of a clinical placement. They felt that this reinforced to trainees that they must keep a record of their activities. Unlike the non-compilers and minimalists, enthusiasts used portfolio documentation to guide the practice areas in which they would assess students, albeit in a high superficial manner. However, although they used portfolio documents to inform and guide them, like non-compliers and minimalists, enthusiasts reserved the right to assess students as and how they thought fit. They used their own personal standards of judgment: *'I do try and make sure to meet regularly with students and that I do assess them in the key areas in the portfolio documentation Like communication skills with patients, or their ability to use clinical protocols when formulating a diagnosis...But at the end of the day what I am most concerned with is satisfying in my own mind that they are basically competent to do the job as I see it, not with filling in the portfolio paperwork. Don't get me wrong. I like the portfolio approach. It's just that, well, I think if you talk to my colleagues they will tell you much the same thing. That it does tend to be too prescriptive and tell you want to do assessment wise with a student or a junior (doctor)...It's like they (the medical school and postgraduate deanery) are trying to remove the need for you to exercise your personal judgment by giving you a form to fill in, in a set way, using prescriptive criteria, and I think you can't expect us as experienced clinicians to agree with that approach'* (Dr White).

4.11 What is important to note here is that in spite of the presence of relatively minor differences between these three groups, all reported that a trainee's portfolio played a highly superficial role in helping them, first, decide what work tasks an appraisee should undertake and be assessed in, and second, form an opinion about the level of technical proficiency possessed by an appraisee about these tasks. Indeed, regardless of if they were non-compliers, minimalists or enthusiasts, interviewee's self-reported accounts of the conduct of the appraisal process indicated that they were all adopting a stance of what was defined as 'paperwork compliance' toward it.

Paperwork Compliance

> *'Its all about ticking boxes and signing forms nowadays.'*
>
> Dr Dillon

4.12 The concept of paperwork compliance was generated from interviewee's accounts of how appraisal was undertaken, especially how they themselves approach trainee supervision and assessment during clinical placements. Interviewee's accounts of their own appraisal experiences reinforced the ritual nature of the conduct of annual NHS appraisal within medicine. Consequently they did play a significant part in the development of this construct. Certainly doctor's accounts of their own appraisals showed their appraisers approached annual appraisal in a form-filling tick-box manner. This means that paperwork compliance may also be said to be present in that context. However verification of this fact would require that doctors involved as appraisers in annual NHS appraisal be interviewed to identify if they adopt this stance when conducting appraisals. This task was outside of the aims of this particular piece of research.

4.13 Paperwork compliance occurs when the paperwork completion requirements of appraisal are fulfilled, with relevant sections of a portfolio completed and an appraisee 'signed off' by their appraiser as either having meet minimum performance criteria or not. However, although the paperwork has been completed, the technical aspects of the appraisal procedures have not been adhered to by the appraiser past a highly superficial tick-box form-filling level. The following comments from Dr Rose encapsulate paperwork compliance succinctly: *'its like this, you fill in the forms in a workmanlike 'doting the I's and crossing the T's', fashion. But its all for the look of the thing. It doesn't mean that you actually have done what you are meant to have done, or for that matter believe in what you have written past a very superficial level. You see, you tend to "bend" the paperwork because you have checked out that everything is OK your own way. So you are just complying with the bureaucratic need to get the paperwork done, and that's all really'.*

4.14 Stated formally paperwork compliance gives the impression that an appraisee has been appraised using agreed minimum performance standards. Typically these have been predefined with regards to occupational specific knowledge, skills and attitudinal competency domains, as well as current best evidenced practice guidelines and protocols. Yet in reality these standards have played a superficial role in helping undertake and be assessed in to be defined as 'competent' at a level appropriate to their career point (i.e. compare a final year medical student and a senior house officer), and b) the level of proficiency possessed by an appraisee in regards to these tasks.

Discussion

5.1 As this paper has already noted, a Foucauldian interpretation of appraisal holds that it acts as an information panopticon; constantly surveying, gathering up and processing appraisees as it seeks to make them ever more calculable and efficient (Townley 1997). However the concept of paperwork compliance draws attention to the fact well recognised in the performance appraisal literature that '*if appraisals fail to meet their manifest purpose, they succeed rather as rituals of employment'* (Pym 1973: 233). In the sense that appraisal may appear to be occurred on paper, but in reality it has been nothing but an elaborate creative tick-box exercise (Checkland et al 2007). Consequently it seems to have failed to achieve its manifest panoptic purpose of ensuring worker productivity, organisational efficiency and institutional transparency and accountability (Armstrong 2005).

5.2 The research reported in this paper is not the first to identify this apparent failure. Redman et al (2000), Smith (2005) and Checkland et al (2007) have all previously noted that appraisal processes possess a tendency to operate superficially within medicine. They argue that doctors tend to engage in creative game playing toward appraisals procedural requirements and performance targets, and furthermore, when questioned on this they tend to rhetorically deploy their specialist esoteric expertise to both normalise and justify their actions (Friedson 2001). Even an author as sympathetic to its position as Townley (1997, 1999) acknowledges in her later work that at the level of everyday practice a central problem facing a Foucauldian interpretation of appraisal is that professionals can and do seek to subvert its bureaucratic-rationality. Similar to the research presented here, she found that appraisal was in reality loosely coupled with professional practice, possessing little or no impact upon it as a result of a clash between the tacit nature of practical professional judgement and the formal rationality of performance appraisal guidelines, protocols and benchmarks (Townley 1999).

5.3 Townley acknowledges professionals use the personal tacit foundations of their expertise to 'trump' the rationality of appraisal's information panopticon, as it seeks to construct them as a '*knowable, calculable and administrable subject'* (Miller and Rose 1990: 5). A key consequence of this is that professional practitioners are able to appear to have met the formal reporting requirements of transparent quality assurance processes, but have in fact continued to operate in much the same way they always have done. With the added benefit that their superficial ritualised compliance with this new governing regime has created a more firmly bounded work space within which to operate without outside interference. Certainly the doctors interviewed for the research reported here seemed to operate with a great deal of personal autonomy, particularly in regards to the conduct of trainee appraisal, and furthermore, felt that once done

annual NHS appraisal allowed them to 'get on with things' as much as they had previously.

5.4 Power (1997) found much the same in his review of the implementation of the performance management tool medical audit. He discovered doctors used their tacit professional judgement to resist being 'colonised' by audit and instead engaged in *'creative compliance and game playing around targets'* (Power 1997:106). With practitioners appearing to incorporate audit into their practice but in reality continuing much the same as they did before. Power found hospital management were often complicit within this process as they tended to overlook such game playing in case acknowledging it undermined public confidence in NHS governance frameworks (Hood 2006).

5.5 For Power (1997) and Gray and Harrison (2004) game playing by doctors concerning clinical governance performance frameworks, alongside managerial collusion in such activity, is the dysfunctional consequence of the increasing contemporary reliance on audit and appraisal as governing tools to ensure greater efficiency, transparency and accountability. Like Townley (1999) they argue that the main reason for the growing dominance of the audit ritual lies in the fact that it 'glosses over' the inability of politicians and managers to in reality control professional forms of expertise, due to the tacit foundations on which professional judgement is based. A state of affairs also recognised by some health policy analysts (i.e. Hood 2006, Salter 2007).

5.6 This paper argues that the concept of paperwork compliance captures doctor's game playing tactics toward portfolio-based performance appraisal. As such it contributes to a growing body of 'control/resistance' sociological literature concerning contemporary developments in the regulation of medicine and quality assurance of health service provision (Friedson 2001, Kuhlmann and Saks 2008). This literature reinforces the limitations of the Foucauldian perspective, due to its inability to adequately accommodate the possibility of resistance in its account of the operation of panoptic disciplinary power (Turner 1995). Certainly, performance management tools such as audit and appraisal may well possess the potential to constrain and shape professional practice, but equally the indeterminate nature of professional judgment means practitioners are often able to subvert and even 'counter colonise' them (i.e. see Berg 1997, Basky 1999, Armstrong 2002, Montgomery 2006).

5.7 In the context of sociological consideration of the decline of medical autonomy, Redman et al (2000) note that counter colonisation is a strategy which to some extent protects collective self-regulatory professional privileges. For example, the growth of co-opted medical -managers in the form of medical or clinical directors has arguably helped maintain collective quality control privileges in the face of growing NHS managerial surveillance and control of medical work (Kuhlmann and Allsop 2008). Certainly research by Sheaff et al (2003) and Waring (2007) reinforces that medical line managers are harnessing their rank and file colleague's perception of threats to professional autonomy and self-regulation as a coercive means of ensuring at least the appearance of adherence to more accountable and transparent forms of medical governance in the clinical practice setting.

5.8 However, it also needs to be acknowledged that the introduction of state endorsed quality assurance frameworks, such as clinical governance, mean that professional decision-making processes and regulatory quality assurance regimes over the last two decades have become increasingly trapped inside a seemingly ever-expanding web of governmental surveillance and performance management (Lloyd-Bostock and Hutter 2008). When considering this state of affairs it should be noted that in spite of its aforementioned weaknesses, a key strength of the Foucauldian view of appraisal is that it recognises that the act of surveillance transforms the object being surveyed (Zuboff 1988). Game playing around performance targets and attempts at counter colonisation only exist within the boundaries of possibilities bound up with the very gaze of appraisals information panopticon (Rose 2000). Consequently, only time will tell what the full affects will be of the series of moves and counter moves currently being played out by the bodies involved in the governance of doctors. Yet one thing is certain. No amount of game playing or counter colonisation can hide the fact that doctors' traditional clinical freedoms and self-regulatory privileges are gradually being transformed by a seemingly ever growing governmental need to make the delivery of esoteric medical expertise and complex health care services more amenable to surveillance, calculation and performance management (Friedson 2001, Kullmann and Saks 2008). For example, the contextual issues highlighted by this paper as contributory factors in the generation of a stance of paperwork compliance toward appraisal ? such as its lack of impact upon working conditions ? are currently being addressed as part of reforms to annual NHS appraisal underway as a result of the forthcoming introduction of revalidation (Chamberlain 2009a).

Conclusion

6.1 To ensure their continued 'fitness for purpose' in the face of a series of high profile medical malpractice cases and growing managerial control of the health care system, the medical profession has had to adopt more open, transparent and inclusive governing regimes which rely upon a risk-aware best-evidenced approach toward medical governance (Kuhlmann and Allsop 2008). Against this background portfolio-based performance appraisal acts as one of medicine's new *'"visible markers" of trust [which as]?tools of bureaucratic regulation fulfil [a] function as signifiers of quality'* (Kuhlmann 2006: 617). Yet the concept of paperwork compliance draws attention to the fact that government and medical elites such as the royal colleges must work together to do more to ensure patients are protected from poorly performing doctors. In short, the inherently messy everyday reality of professional practice may be far too complex for the gaze of performance appraisals information panopticon to capture anything other than a pale imitation of it; but rather it capture this than it be nothing more than a creative tick-box exercise. For a certain degree of game playing around performance targets by doctors is perhaps inevitable given the nature of their expertise and ability to counter colonise the very tools which seek to control their performance. But such game playing must not be glossed over. After all, Shipman was only able to commit the crimes he did because the medical regulatory system failed to live up to its claim to be transparent and publicly accountable (Smith 2005). Consequently, current developments in the governance of doctors and the

performance management and quality assurance of medical work, such as the introduction of revalidation, must be analysed by sociologists as part of a broader disciplinary concern with their impact on collective self-regulatory privileges as well as individual doctor's traditional clinical freedom at the bedside. The research detailed in this paper has therefore established an invaluable baseline of rich qualitative data in a hitherto under researched area that it is hoped will help other researchers in years to come judge the long-term impact of current reforms in the performance management and quality assurance of medical work.

Table 1

Biographical details of the participants interviewed for the study (all names are pseudonyms).

Dr White, General Practitioner, age 38, Female, White
Dr Lamb, General Practitioner, age 44, Male, Chinese
Dr Grading, General Practitioner, age 47, Male, White
Dr Brown, General Practitioner, age 43, Male, White
Dr Summer, General Practitioner, age 55, Male, White
Dr Philips, General Practitioner, age 57, Male, Black: Caribbean
Dr Sullon, General Practitioner, age 41, Female, White
Dr Terrence, General Practitioner, age 54, Male, Asian: Pakistani
Dr Williams, General Practitioner, age 49, Male, White
Dr Manner, Accident and Emergency, age 44, Male, White
Dr Roome, Accident and Emergency, age 37, Male, White
Dr Rose, Accident and Emergency, age 41, Male, White
Dr Simon, Accident and Emergency, age 39, Male, White
Dr Pendergast, Accident and Emergency, age 42, Male, White
Dr Took, Accident and Emergency, age 44, Male, Chinese
Dr Grim, Accident and Emergency, age 38, Female, White
Dr Orion, General Medicine , age 61, Male, White
Dr Ingrade, General Medicine, age 39, Male, White
Dr Black, General Medicine, age 41 , Male, White
Dr Bright, Clinical Chemistry, age 45, Male, White
Dr Goode, Medical Microbiology, age 38, Male, White
Dr Smith, Obstetrics and Gynaecology, age 49, Male, Asian: Pakistani
Dr Redmond, Obstetrics and Gynaecology, page 53, Male, White
Dr Pillon, Dermatology, age 55, Male, White
Dr Lime, Gastroenterology, age 46, Male, White
Dr Fraser, Gastroenterology, age 45, Male, White
Dr Tandman, Biochemistry, age 37, Female, White
Dr Grade, Geriatric Medicine, age 55, Male, White
Dr Hayes, Geriatric Medicine, age 57, Male, White
Dr Baker, Endrocology, age 45, Male, White
Dr Blue, Endrocology, age 59, Male, White
Dr Dillon, Surgeon (ENT), age 54, Male, White
Dr Wheat, Surgeon (ENT), age 47, Male, Asian: Indian
Dr Sandy, Surgeon (ENT), age 54, Male, White
Dr Tanner, Surgeon (Cardio), age 43, Male, White
Dr Percival, Surgeon (Cardio), age 47, Male, White
Dr Taylor, Surgeon (Cardio), age 41, Male, White
Dr Jumper, Surgeon (General), age 52, Female, White
Dr Lime, Surgeon (General), age 61 , Male, White
Dr Light, Surgeon (General), age 42, Male, Chinese
Dr Blue, Surgeon (General), age 48, Male, White
Dr Redman, Surgeon (General), age 51, Male, White
Dr Griffiths, Surgeon (General), age 45, Male, White
Dr Tealman, Surgeon (General), age 47, Male, White
Dr Greyhead, Surgeon (General), age 43, Male, White
Dr Yellowhouse, Surgeon (General), age, 46, Female, Asian: Pakistani

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