The experience and professional development of medical appraisers

Abstract

This paper explores the experiences of GP appraisers working in a new setting (Jersey) with appraisees new to the process. Findings were interpreted using the learning theory, 'situated cognition', to shed light on the experience of appraisers working with new appraisees more generally. This is the first time appraiser development has been considered in this way and this paper contributes to new understandings of workplace learning. Rich qualitative data derived from transcripts of nine in-depth interviews with GP appraisers were analysed thematically in a rigorous and iterative process. GP appraisers working in an unfamiliar environment shared a common sense of culture shock and discomfort. Initially, they needed to work much harder than usual to establish rapport and credibility, but by the second round of appraisals, appraisers were reminded of the power of appraisal. The innovative application of 'situated cognition' helps to explain why appraisers felt like 'novices' in Jersey and how they were required to reconstruct their professional knowledge. Appraisers can be helped to develop professionally if they are offered a mix of appraisal-related activities in new places and with new people. Such implications for educational support apply internationally where doctors are involved in a process of peer review as part of on-going professional development.

Introduction

Since 2002, all General Practitioners (GPs) in England have been required to take part in an annual appraisal. The model is one of peer-appraisal and many GPs have taken up the opportunity to become medical appraisers, participating in training and

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quality assurance [1]. Since 2012, the process has become more complex, as all medical practitioners must take part in a process of revalidation (normally over a five-year cycle) to demonstrate they are up to date and fit to practise. Revalidation and appraisal are closely linked, as supporting evidence from annual appraisals feeds into the revalidation process. This evolution has had profound implications for the professional development of medical appraisers.

Appraisals provide the opportunity for GPs to reflect on their professional practice and may aid their professional development [2,3]. Like all doctors, GPs are obliged to demonstrate that they reflect on their practice [4]. The process of appraisal has been found to enrich learning, professional development and practice [5]. The best appraisers can guide the appraisee in an appraisal to help them enhance and further develop their skills of reflection and insight [6]. An appraiser's skills have been found to contribute to the overall effectiveness of an appraisal [7]. Development on the part of appraisers is important and yet little is published about how appraisers learn the skills to appraise and develop their own professional practice [8,9,10,11]. This study aims to initiate further discussion in this area and is part of a broader, on-going programme of work looking at the role of the medical appraiser [8,9,10]. Given the centrality of appraisal within revalidation, the resources devoted to it and the importance of appraisal to the profession, a better understanding of appraiser development is essential.

This paper draws on data originally collected in the context of a project examining the impact of introducing appraisal into a non-NHS healthcare system (i.e. Jersey). The specific analytic focus here concerns the experiences, learning and professional development of GP appraisers.

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Jersey is one of the Channel Islands, off mainland Britain. Like British doctors, Jersey doctors are registered with, and licensed by, the General Medical Council. They work outside the National Health Service (NHS) and general practice is paid for partly by a contribution provided as a state benefit and partly by a fee paid by the patient at the point of care. The different nature of the health service in Jersey provides a distinctive opportunity to study GP appraisers working in a new, unfamiliar setting with appraisees new to the process. Looking at their practice sheds light on the experience of appraisers more generally, identifying important implications for their educational support and professional development. This is of interest not just nationally but internationally where peer review is part of professional development.

Methods

Research design

The aim of this research is to make sense of participating appraisers' experiences of appraising new appraisees in Jersey. The authors form a collaboration of practitioner researchers and researchers to draw nuanced interpretations of the accounts appraisers give of their professional practice. Such a collaborative framework of research is a form of practitioner research that values professional experience and helps to reveal those aspects of appraiser practice that may otherwise have been taken for granted [12]. In the findings section of the paper we hear the 'voice' of the medical appraisers given in interviews, to explore the ways in which they make sense of the appraisal process and the appraiser-appraisee encounter. In the discussion section the learning theory of 'situated cognition' is

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applied to help create a more complete picture of how the appraisers changed and developed.

Data collection

Nine in-depth qualitative semi-structured interviews with GP appraisers were conducted by an experienced qualitative researcher exploring their experiences of the appraisal process. All the original Jersey appraisers were asked and agreed to take part in the study. These appraisers were originally invited to go to Jersey as they were experienced mainland appraisers (defined as having already appraised regularly for a minimum of two years). At the time of being interviewed they had all conducted at least two consecutive rounds of appraisals in Jersey with at least two different appraisees each so with a range of experience in that setting they were valuable 'key informants' [13]. Interviews lasted around 45 minutes each.

Ethical considerations

In carrying out the research we adhered to British Education Research Association's (BERA) Ethical Guidelines for Educational Research [14]. Informed consent was gained from participants, including the right to confidentiality and to withdraw without explanation. The interviews were digitally recorded and once transcribed, all the data was anonymised and the recordings deleted. Ethical approval was granted from the University of Winchester.

Data analysis

Our analysis used the process of induction to derive themes from the data [15]. One researcher carried out the initial review of the data, iteratively developing themes that provided a framework to organise and interpret the data and represent the data after analysis. The rest of the thematic analytic process was collaborative with three

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coders (RL, JB, BO) undertaking the coding of interview transcripts independently. The results of the coding were then shared and reviewed until there was convergence [16]. The rationale underpinning the selection of extracts chosen for inclusion in the paper is that they exemplified the 'outcomes' of a broader analytic endeavour and do not constitute all of the analysis.

Findings

The main themes that arose from the data analysis were: culture shock; situations of uncertainty; establishing the role of the appraiser; changes in practice; evidence of success; and a reminder of the power of appraisal. These themes are explored in turn to provide an account of appraisal practice from the appraisers' point of view.

Culture Shock

First impressions: differences

Appraisers from the mainland anticipated that the professional activities of the GPs on Jersey would very much mirror their own in the NHS. In fact, appraisers said that they found it a bit of '*a culture shock'* (Participant 7), as they discovered differences in the way medicine was practiced. '*It was quite an eye opener, the way that they practise medicine differently*' (Participant 3). The patient/doctor relationship varies from that in the UK because of the different structure of healthcare provision. Appraisers described how Jersey GPs '*are doing things for money'* and '*are quite business like'* (Participant 7).

There were significant differences in the resources available to GPs on Jersey as compared to the mainland. The computers and information systems needed to feed into the appraisal process were not necessarily in place. Little was done in the way

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of audit. Due to a lack of computerisation, medical notes recording the management of patients were not searchable and there was no patient registration system, so a patient could be registered at more than one surgery.

'*I think the first couple of appraisals I did in Jersey was quite a shock because of my preconceived ideas, my prejudices of what they would be doing would be the same as us, and it actually turned out that it wasn't in many areas*' (Participant 3).

Second impressions: similarities

After the initial culture shock, appraisers found that underneath the initially constructed contrast there were many familiar things. The appraisal process is '*very similar*' (Participant 7). It is about having '*a conversation*' about how they practise, what they do and how they do it (Participant 1).

Just because the system is different, doesn't mean you can't help people explore what their development needs are, and if their development needs mean changing a system, helping them explore that, even though it's not the system that you're familiar with (Participant 2).

Although the appraisers' first impressions were of surprise, and even shock, at discovering significant differences between general practice on Jersey and the mainland, this was later tempered by their perceptions of familiarity in the actual process of appraisal.

Situations of uncertainty

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As experienced appraisers, their level of skill and experience were such that they were expected to get up to speed in this new environment quickly and cope with a degree of uncertainty when they started appraising.

It was experienced appraisers who were chosen to go, and the reason we were chosen was because it was felt that we had the skills to adapt to what we were doing to a different context (Participant 2).

In reality these 'experienced' appraisers felt '*very inexperienced*' (Participant 3) in this new situation and were handling a greater deal of unpredictability than usual.

I think even my initial ones, I still gave a good appraisal, but my internal turmoil was harder to hide (Participant 3).

In response to this uncertainty, appraisers had to consciously think about what to do and work harder in making professional judgements about their practice than they had done previously.

Honestly the learning curve was hugely steep, but after the first three appraisals, I really felt like I had a much better grasp, and after …nine, I really had a much better understanding (Participant 1).

Appraisers believed they could not necessarily have been taught how to deal with these situations of greater uncertainty. After the first few appraisers had been to Jersey, an induction process was introduced to help appraisers understand the context in which they were going to be appraising. Nevertheless, appraisers felt learning was best achieved through doing appraisals in this new place.

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Someone speaking about the system, it still wouldn't have been the same as talking to the doctors at the coalface in Jersey, and then getting a grasp for what they do (Participant 1).

The best person to teach you is your first appraisee (Participant 4).

Establishing the role of the appraiser

When appraisal was first introduced in Jersey there was some suspicion and anxiety amongst Jersey GPs.

As individuals, I think … people were not exactly scared but … fairly cautious and wary about what was going on (Participant 6).

This was perhaps not surprising as these GPs had not taken part in any formal appraisal process previously. It is reminiscent of the initial response to GP appraisal on the mainland. Appraisers from the mainland were contracted to carry out appraisals rather than Jersey doctors. This 'externality' is unusual as, typically, appraisal has been carried out by 'peers'. As general practices are in direct competition on Jersey, it was feared that local GP appraisers might find out things that were commercially sensitive and '*[use] that to enhance their own practice … compete directly or … run the practice down'* (Participant 6). Appraisers found it necessary to establish themselves as 'outsiders' in the role of the appraiser to gain credibility and confidence in the confidentiality of the process.

As well as concern about who the appraisers might be, there was anxiety about what they were there for and who would see the outputs of their appraisals.

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When we first arrived, I think they felt it was like the cops arriving, and I had people literally saying … this is my drug list, my record of it staying the right temperature … as if we were the Health Commission (Participant 5).

Appraisers were met with concern from Jersey appraisees about what appraisal meant for them.

I think in the beginning before we got there, they felt negative about appraisal, and having to produce their appraisal files and the evidence (Participant 5).

This fear manifested itself in a reluctance to engage with the process and sometimes appraisees submitted insufficient pre-appraisal paperwork for their first appraisal.

A lot of them hadn't done any preparation (Participant 7).

Appraisers spent time getting appraisees on board and reassuring them that appraisal was for their benefit.

Changes in practice

Appraisers needed to make changes to their professional practice in this new situation on Jersey. They adapted the questions they asked to make them more relevant to Jersey doctors.

I think it's more about that facilitative role in appraisal of listening to the situation, which was really new for us, and saying… so what's the way forward here, how could you change this… if that's not commercially viable, what would be commercially viable… so we don't come up with the solutions, but we help them explore what would work in this situation (Participant 2).

Reminder of the power of appraisal for appraisers

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Appraisers were nurturing people new to appraisal, which was gratifying because the rate of progress is greater for novices. This was refreshing for appraisers even though it was hard work.

Because they have been dealing with people who have no experience of appraisal, and therefore no preconceptions, in a different environment … a) they've had to learn about Jersey context and b) they have been nurturing people from scratch, which is a very rewarding thing to do (Participant 4).

There is not much opportunity to appraise doctors who are new to appraisal in the UK (except with junior doctors doing their first appraisals). Mainland appraisees are now very experienced. They know what to do for their appraisal and they tweak their practice, but they do not continue to make wholesale change. This may be why appraisers were keen to continue appraising on Jersey. '*I couldn't bear the thought of giving this up'* (Participant 9).

The power of appraisal may have been diminished for some on the mainland, particularly with revalidation requirements and the perception that appraisal can feel like a tick box exercise. Indeed, some appraisers may have experienced '*appraisal fatigue*' (Participant 8). Going to Jersey helped appraisers remember how empowering appraisal can be.

The impact on the mainland appraisers who've gone, some of them have been re-enthused, re-energised, challenged, stretched, so there is a benefit for the people who've gone in and delivered the appraisals … as well as for the doctors on Jersey (Participant 4).

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Discussion

We have described the practice of medical appraisers entering a new situation and shown how they responded and developed at the same time as the doctors they appraised. In this section we draw on the theory of 'situated cognition' to explore the meaning of our findings in terms of how appraisers change and develop professionally and we then identify the implications for ongoing educational support for appraisers and for future research. Before this, we discuss the strengths and limitations of our research.

Strengths and Limitations

The context of the study is Jersey where the healthcare system is significantly different to the rest of the UK, most obviously because General Practice is in part privately funded. This aspect of the research may be of particular interest to those involved in private health care in medicine and health and care professionals within more commercial settings (e.g. pharmacists). It may be less immediately apparent how it is of value to appraisers on the mainland who have been involved in a system that is already up and running. However, it provides a distinctive opportunity to look at how GP appraisers deal with and grow through a new situation and appraisees new to appraisal.

The findings are based on a secondary analysis of qualitative data. This is a well recognised research practice but a potential disadvantage of this approach may be an absence of memories or understandings of what is felt or seen during the research process [16]. This issue was mitigated in this study with the involvement of three of the paper's authors in the original research. This meant there was a

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'closeness' to the data when it came to inductively looking for evidence of appraiser development.

Situated Cognition

This learning theory recognises that the acquisition of skills and knowledge cannot be viewed as separate from the context in which they are learnt. It challenges the assumption that knowledge can simply be transferred across boundaries. Learning is said to be 'situated, being in part a produce of the activity, context, and culture in which it is developed and used' [17,p.32]. When they are used in a different context, knowledge and skills always need to be reconstructed [18]. These ideas are particularly valuable when investigating workplace learning and have been used in clinical settings to understand how contextual factors influence learning, for example, in doctor-doctor consultations [19].

In our study, the appraisers were already accomplished, understanding medical appraisal and how to do it. They had the necessary skills and experience; what Bourdieu [20] refers to as 'capital' and 'dispositions'. When they started appraising on Jersey, they came across different ways of doing things and entered a situation of great uncertainty. Uncertainty is an integral part of professional practice [3,21]. Appraisers found themselves deep within Schön's 'swampy lowlands' [3,p.42], not understanding the context and not immediately knowing how to proceed. As expert, confident appraisers this feeling was unusual and unexpected. They experienced very forcefully the impossibility of directly transferring their expertise to this new situation. They had to adapt and re-contextualise their appraisal skills and re-establish their role within this new context.

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The situation was very developmental. While the appraisers certainly reconstructed knowledge, they could also be seen to have reconstructed themselves [20]. They were used to feeling confident and sure they could deal with any appraisal situation. In Jersey, they felt like 'novices': they had to consciously think about what to do. In becoming aware of their 'blind spots', they became 'consciously competent' [22]. They were required to use their professional capabilities more than in their mainland appraisal encounters. Their reflection on these new experiences enabled them to see their practice in a new light. Appraisers recognised this was not something that could be taught as it had to be experienced. Their expertise was always under construction through involvement in appraisal related activity, 'learning as becoming' [20,p.633). As a result of these processes, appraisers enhanced their appraisal facilitation skills to respond to the demands of their role as Jersey appraisers.

This study suggests that the ongoing development of appraisers can be facilitated by raising their awareness of the complex dynamics of learning in the workplace. There is no common sense transfer of knowledge, with knowledge simply stored, retrieved and transplanted between settings. Rather, learning is situated in context, with a reconstruction of knowledge needed for each new environment encountered [20]. It seems likely that this is subtly true for every appraiser-appraisee pairing but was brought into focus here by the differences in general practice on Jersey. Appraisers should be taught to recognise the importance of contextual factors and the opportunities presented by greater responsiveness to such factors. While it may be valuable for appraisers to be prepared by listening to others, this is no substitute for personal experience.

Implications for the professional development of appraisers

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The challenges of using familiar skills in unfamiliar contexts is one important mediator to appraiser development. Insights from situated cognition have been helpful in exploring how medical appraisers enhance and develop their own professional practice. GP appraisers working in an unfamiliar environment shared a common sense of culture shock and discomfort requiring them to bring their existing skills to conscious awareness and use them mindfully. They had to work harder than usual to establish rapport and credibility and they had to adapt their practice to the context. By the second appraisals, they were reminded of the power of appraisal to facilitate positive change and working in a different context kept them 'fresh'. This finding may be useful in helping to retain and refresh appraisers.

Particularly in the context of the time and resources devoted to appraisal and the pivotal part appraisal plays in the ongoing process of revalidation, appraisers need to be well-trained and supported. A mix of appraisal related activity in new places, and with new people, will provide them with opportunities to enhance their appraisal skills, reconstruct their knowledge and develop professionally. While in this study a change in location provided this opportunity, such opportunities may well arise when appraisers work across health care settings, within various specialties and in multi-professional teams. Those responsible for the educational support and professional development of appraisers, as well as appraisers themselves, need to consider how this refreshment in their context can best be achieved. Although this is a UK-based study, its implications speak to international practitioners and researchers where doctors are involved in a process of peer review as part of their ongoing professional development.

Future research

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Going forward, all medical appraisers need to be encouraged to seek out new appropriate professional contexts within which to develop their practice. Further research to explore the ways in which appraisers professionalise their practice and develop their appraisal skills will build on these ideas, particularly in the context of the need to calibrate professional judgements in appraisal. In the meantime, it seems likely that the appraisers learned as much through appraising on Jersey as the doctors did through being appraised. This is a less well documented benefit of appraisal that deserves further consideration.

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