



Psychological Factors in Appraisals

The hardwired block to objectivity

Appraisals are typically approached with a mixture of scepticism and distaste, both by those being appraised and the appraiser themselves. However, with so much weight placed on the appraisal process as the primary method of assessing doctors for revalidation, it is vital that appraisal is both acceptable and effective at delivering its purpose. NHS organisations often seek to improve the appraisal process by providing training for appraisers, however, that training seldom includes one of the most significant confounders to appraisal effectiveness – psychological difference. This paper highlights some of the most important aspects of difference and how they impact the appraisal process.

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Who conducts appraisal?

Each organisation needs to appoint a Responsible Officer who will ensure that appraisal is conducted effectively and who will ultimately sign off on the appraisals themselves. However, although this person may well conduct appraisals themselves, the sheer volume of appraisal to be conducted means that the function of delivering appraisal will predominantly fall to a service level. In most instances, appraisal will be conducted by the clinical lead or director and this raises the first issue at a psychological level.

Clinical service leads or directors are already a selected group from a psychological perspective. There tends to be four main reasons why someone ends up as a clinical director:

- They aspired to the position of head of service
- It was their turn, in a rotating pattern
- Nobody else would volunteer and so they stepped up to help
- They felt that the last incumbent did not do it correctly

Each of these tells us something about the individual and any individual in any service could have ended up as clinical director for one or more of these reasons. However, there are also distinct patterns and in certain services this could be a recipe for bias in the appraisal process. For example, surgical specialties are more likely to have competition for the lead role, whereas medical specialties lean more towards reluctant volunteers or those wishing to do it differently. Each of these individuals would appraise differently, with different hot spots and 'crimes' linked more to themselves than the person they are appraising.

In essence, each distinct cluster of like-minded individuals has a blueprint for clinical, managerial, leadership & personal effectiveness, against which they hold themselves to account and judge others. If everyone ran the same blueprint this wouldn't be an issue but the fact that we don't introduces interpersonal psychological bias that must be controlled for if appraisal is to be truly effective.

Bob, Clinical Director, Obstetrics, Gynaecology & Paediatrics

Bob set his sights on being clinical director from an early stage and when the role came up he, along with 2 colleagues, applied for the role. After a small competition, including presentations and interviews, Bob was appointed. Bob considered himself an excellent doctor, with first rate results, low complication rates and a heritage of being highly productive. He was a 'get stuck in' kind of person that drove himself hard both personally and professionally and he felt proud of his achievements in life, often rewarding himself with a 'treat' such as that nice new superbike in his garage. Bob felt appraisals were just one more challenge to be nailed and was confident that his sound communication skills and quick grasp of critical information would put him in good stead.

Jenny, Consultant Paediatrician

Jenny had been a Consultant Paediatrician for some 12 years now, was well liked by her patients and parents and enjoyed a full and balanced life, with considerable community interests in the small village in which she lived. She had an active social life, although currently much time was spent supporting her 2 teenage children through GCSEs and A-levels. Her work was important to her and she was an active participant in the department, often volunteering for roles where others seemed reluctant to step forward. Her very open-door approach to healthcare seemed to be very appreciated by her families and she had quite a collection of thank you cards lined up on her shelf.

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The Appraisal

When Bob received the pre-appraisal figures and feedback for Jenny, he quickly digested it and determined that Jenny appeared to be basically sound as a doctor but not the swiftest member of the department. She appeared to follow up patients more times than her peers on average. She seemed to be reluctant to take on managerial responsibilities and he deduced that she struggled to say 'no', resulting in being a bit of a dumping ground for other people's rubbish. He wondered if there was a pattern here and that the pattern was 'lack of assertiveness', which would be easy enough to get sorted. "Nailed it" he thought, looking forward to the appraisal interview.

Jenny had not been looking forward to the appraisal interview. She was worried how it would go and concerned whether it would be fair and objective. She was less worried about her medical competency but she intended to raise some questions about being overwhelmed and also perhaps moving to 7 or 8 PAs to spend a bit more time with the children.

The actual appraisal interview arrived. After initial pleasantries, Bob got straight down to business. "I don't think this will take too long" he said, "everything's basically sound. Just a few bits and pieces to chalk up in the personal development plan". "Oh?" said

Jenny. "Yes, I don't think we need to spend much time on your clinical work, as long as your portfolio has the right CPD but I think if you can improve your assertiveness you'll be able to get more done, see more patients and get your efficiency up to par with your colleagues. Can we stick an Assertiveness course down in your PDP?". "OK" said Jenny hesitantly. "Great. That will nail the figures for next time because I'm sure that more control over your patients will mean you get waylaid less. Anything you want to bring up? If not, we can stamp that one done and get back to the day job."

Other than listing a few clinical courses she wanted to attend, Jenny didn't have much to say. She didn't feel it was the right time to raise the drop in PAs because she already felt criticised for her work rate and the last thing she wanted was for everyone to think she wasn't pulling her weight. She decided that this was just the way appraisal was, mostly about ticking the box and moving on. At least it hadn't taken hours, even if she didn't feel listened to.

Our Observations

This is a fairly typical example of mismatching between appraisee and appraiser, resulting in an uncomfortable appraisal environment and a poor appraisal outcome. It would be easy to find apparent fault with both parties:

- Bob reached an early conclusion and this led him in the appraisal
- Jenny didn't speak up, consistent with Bob's opinion about assertiveness

However, the exchange and conclusions are entirely predictable given the two individuals involved. Arguably both would have benefited from greater self-awareness of their own natural traps but in truth, the Trust has a responsibility to ensure that those delivering appraisal are trained sufficiently to remove psychological bias. In effect, both were set up to fail but ultimately the Trust is the loser by not resolving specific issues or getting the best from Jenny. The appraisal will have done nothing for the relationship between Jenny and Bob, as she's clear it didn't work for her and Bob is the source of that.

Jenny is most probably altruistic-nurturing motivation, resulting in generally low assertion and a high consideration for her impact on others, as well as the strong tendency to go the extra mile for patients and help where help is needed. However, this does impact the appraisal pathway considerably because:

- Jenny needs a warm, friendly approach so that she relaxes and feels able to raise issues of concern without having to 'force' them in

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- She has a relatively high need for praise, at least in balance, to feel that she is contributing and that everything is OK and without this a tendency to feel criticised
- Direct feedback can feel like personal criticism

Additionally, Jenny is unlikely to aspire to management positions because they often involve working in isolation, planning, forecasting etc and frequently involve telling people what they can't do or what they've done wrong – none of which are appealing to her. Furthermore, she actually likes spending time with her patients and has a natural tendency to give them as much time as they need, compensating for this by taking non-patient work home with her.

Bob, on the other hand, is assertive-directing motivation and consequently favours directness in communications and feedback. Being very practical and driven, he is very much 'get in, find a solution, get back out' and would have a naturally low tendency to spend time on what doesn't need it i.e. the good things. He is also likely to:

- Speak more than listen, often leading the conversation
- Put an early conclusion on the table
- Appear quite firm and in control
- Actively manage the time to keep things on track

All of these contribute to an appraisal environment that is unfriendly, overly formal and therefore threatening to Jenny (although it wouldn't be any of these things to Bob, if

he were being appraised). Bob is going to struggle to get Jenny to contribute under these circumstances and so doesn't discover what he really needs to discover, also leading him to think his conclusions are right (or she'd speak up, surely?). There is unlikely to be natural rapport between them and on an everyday basis Jenny could experience Bob as abrupt, overly assertive and somewhat unfeeling, whereas Bob might experience Jenny as nice but soft and easily lead. All of this predisposes the appraisal outcome.

Bob also tends to notice performance, figures, targets, major achievements and could easily assume that a lack of time spent on management projects is a career or contribution failing, not a preference as it clearly is in this case. Performance apparently at odds with peers would bother Bob, who'd want the best results and would see attaining them as a challenge or even a competition. Consequently, this becomes the issue that he feels needs sorting out, even though Jenny clearly delivers an exceptional experience from a patient perspective, something to be celebrated but which is unfortunately overlooked (as this tends to be naturally deleted by Bob, in favour his preferred 'performance' factors).

These are just a few of the observations on a process that delivered a compliant appraisal, certainly ticked the box without missing anything 'vital' but fell well short of a good appraisal, simply because of the psychological difference between these two people. It doesn't get any easier when Bob appraises someone just like him. Under these

circumstances, neither are likely to notice certain blind spots and could easily judge everything to be fine when in fact there may be important issues that need addressing.

The solution?

Ideally, the Trust needs to invest in appraisal training that covers standard appraisal effectiveness as well as how to compensate for or manage psychological difference. This would include ensuring that individuals fully understand their own blind spots or traps, as well as how to set up and conduct appraisals differently for the individuals they are appraising. The manner in which feedback is given should be tailored to the individual, with special consideration over feedback that addresses adverse findings.

By understanding the appraisee and self, appraisers can be more objective, less negatively impactful and can spot issues and opportunities that individuals are blind to themselves. This creates a richer outcome, leading to more benefits for Trust and individuals alike. The reduction in negative associations with appraisals, along with the improvement in value, leads to greater engagement, even enthusiasm for appraisal, ultimately restoring it to its rightful place as a vital component of an organisation committed to strong performance through its people, not in spite of them.

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