How Do Physician Executives Understand Performance Review and Assessment? A Longitudinal Q-method Analysis in a Public Health Organization

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Introduction

- Performance review and assessment (PRA) (aka performance appraisal) is a controversial practice in public healthcare organizations
- PRA is an arena where conflict arises between deontological canons of medical profession and managerial accountability
- RQs: How do physician executives (aka doctor managers) understand PRA? Do their attitudes towards PRA change over time?

Introduction

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- Yes, people behave differently because they change their attitudes (if we assume that attitudes affect behavior)
- Yes, people change their attitudes because they change their behavior (if we assume that people seek consistency between attitude and conduct)
- Well, maybe no, because people may behave as required or expected while they hold reservations about what they are required or expected to do

Method

Mixed method longitudinal study

- Participant observation of PRA interviews with 12 physician executives in 2011-2013
- Exploratory semi-structured interviews with 15 physician executives in 2013
- Q method study in 2013 (40 respondents)
- Q method study in 2016 (33 respondents)
- Semi-structured interviews on the results of this study in 2017

Method

Types of claims	Level of analysis	Cultural perspective			
		Individualistic	Hierarchical	Egalitarian	Fatalistic
Designative	Individual	(s1) PRA serves to recognize what I am worth.	(s2) PRA serves to distinguish who is committed more from those who work less.	(s3) PRA serves to reinforce the sense of teamwork with colleagues.	(s4) PRA serves to conduct performance assessment in a bureaucratic and formalistic way.
	Organizational	(s5) PRA serves to recognize my contribution to the organization.	(s6) PRA serves to recognize those who contribute more to organizational goals.	(s7) PRA serves to create a climate of collaboration.	(s8) PRA serves to conduct performance assessment as required to comply with legislation.
Evaluative	*Individual*	*(s9) PRA makes my work more responsible and self-directed.*	*(s10) PRA helps to control the conduct of individuals.*	*(s11) PRA helps avoiding favoritism.*	*(s12) PRA is ineffective to motivate and stimulate individuals.*
	Organizational	*(s13) PRA helps understanding the role of individuals in the organization.*	*(s14) PRA helps to make the organizational activities more consistent.*	*(s15) PRA makes everyone feel part of the organization.*	*(s16) PRA is ineffective to improve services for patients.*
Advocative	**Individual**	**(s17) PRA should be based on specific criteria for each type of job profile.**	**(s18) PRA should differentiate more between those who work more and those who work less.**	**(s19) PRA should avoid creating tensions and rivalries between colleagues.**	**(s20) PRA should take the voice of the evaluated in greater consideration.**
	Organizational	**(s21) PRA should place a greater weight on the individual rather than group or organizational performance.**	**(s22) PRA should be based on more challenging goals.**	**(s23) PRA should be based primarily on indicators of group performance.**	**(s24) PRA should be also based on the voice of medical and nurse staff.**

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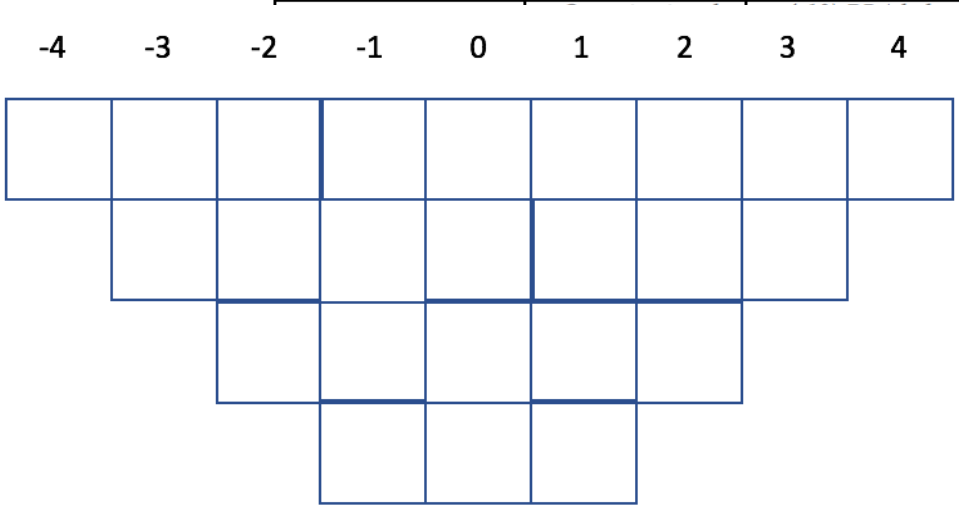


Results

Table 2. Factor matrix with defining sorts (in bold), 2013 data.

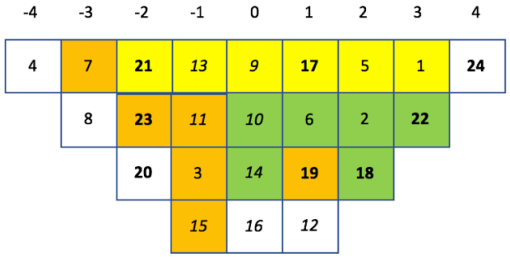
ID	Factors		
	1	2	3
1	0.0733	-0.3270	**0.5166**
2	0.1249	**0.6484**	-0.3097
3	0.0425	-0.0465	**0.6843**
4	0.5161	0.0850	0.3224
5	**0.6682**	-0.2500	0.1763
6	0.2911	0.1639	**0.7301**
7	**0.7670**	0.0170	0.1305
8	-0.0109	0.2872	-0.0793
9	**0.7514**	-0.0104	0.3163
10	-0.1067	**0.6573**	-0.0469
11	**0.6118**	-0.2528	-0.1177
12	**0.5114**	0.0371	0.2693
13	**0.6283**	-0.3240	0.3055
14	-0.2803	**0.6568**	0.3141
15	**0.7011**	0.0481	-0.1022
16	0.1415	**0.5450**	0.0627
17	0.0250	0.0879	0.1296
18	0.1143	0.0150	**0.5922**
19	-0.1080	**0.7771**	0.0460
20	**0.5752**	0.2853	-0.4172
21	0.1223	-0.4143	0.5080
22	0.0178	**0.6716**	-0.2127
23	-0.0257	0.0623	**0.5380**
24	0.4225	0.1014	0.2402
25	**0.5614**	-0.2003	0.1364
26	0.2980	0.1372	**0.6476**
27	**0.7334**	0.1693	0.1986
28	-0.0789	0.2133	0.0331
29	**0.6085**	0.0501	0.3586
30	-0.0184	**0.6898**	0.0358
31	0.4738	-0.4115	-0.0988
32	**0.6528**	0.0833	0.2522
33	**0.5760**	-0.3805	0.1223
34	-0.3352	0.4620	0.2030
35	**0.6462**	0.0066	0.0561
36	0.1847	**0.6259**	-0.0632
37	-0.1063	0.0383	0.1030
38	0.0514	0.0154	**0.6760**
39	-0.0060	**0.7535**	0.1246
40	**0.4758**	0.1724	-0.2066
% explained variance	18	14	11

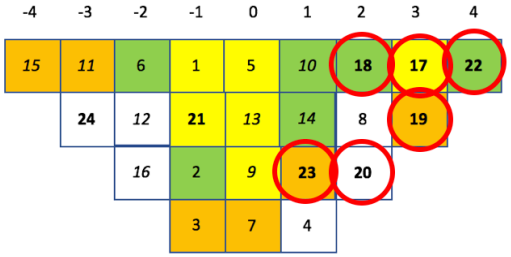
Table 6. Factor matrix with defining sorts (in bold), 2016 data.

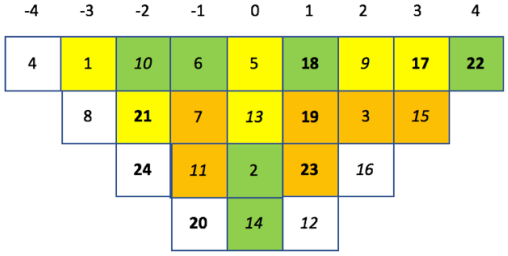
ID	Factors		
	1	2	3
1	- 0.3239	**0.7962**	0.0828
2	0.0241	**0.8580**	- 0.1840
3	0.3366	- 0.0263	0.2648
4	**0.7153**	0.3064	0.0704
5	0.3164	0.0447	- 0.2905
6	0.1429	**0.6762**	0.4560
7	- 0.0367	0.2322	**0.7717**
8	**0.7222**	- 0.2204	0.1007
9	**0.8204**	- 0.1688	- 0.1551
10	0.1969	0.2148	- 0.0370
11	0.3691	- 0.2752	**0.7882**
12	- 0.3211	**0.7382**	0.0141
13	0.0047	**0.7700**	- 0.1980
14	0.3503	0.1117	0.2207
15	**0.7302**	0.3463	0.2497
16	0.3597	0.0288	- 0.2055
17	0.1586	**0.6323**	0.4978
18	- 0.1356	0.1696	**0.7585**
19	**0.6501**	- 0.2388	- 0.0296
20	**0.8131**	- 0.1877	- 0.0836
21	0.2816	0.2179	- 0.0278
22	0.3211	- 0.1731	**0.7815**
23	- 0.2114	**0.8363**	- 0.0151
24	0.1018	**0.5721**	- 0.2847
25	0.3170	- 0.0415	0.1602
26	**0.7183**	0.1717	0.2432
27	0.2075	0.1112	**- 0.5193**
28	0.1465	**0.6769**	0.4315
29	- 0.4060	0.1729	**0.6105**
30	**0.5998**	- 0.3354	- 0.0190
31	**0.6730**	- 0.1780	- 0.1093
32	0.3498	0.0810	- 0.0388
33	0.2302	- 0.2476	**0.7906**
% explained variance	19	18	15

Results

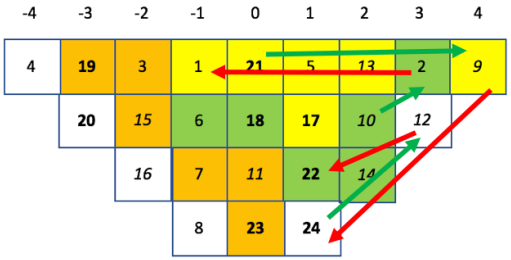
2013

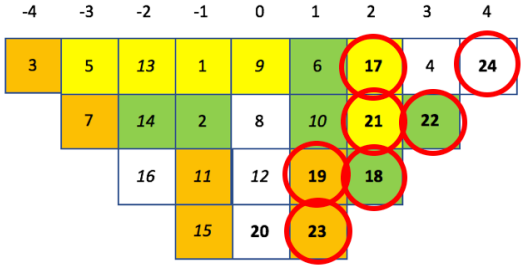


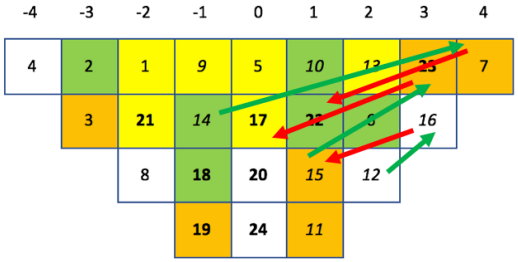




2016





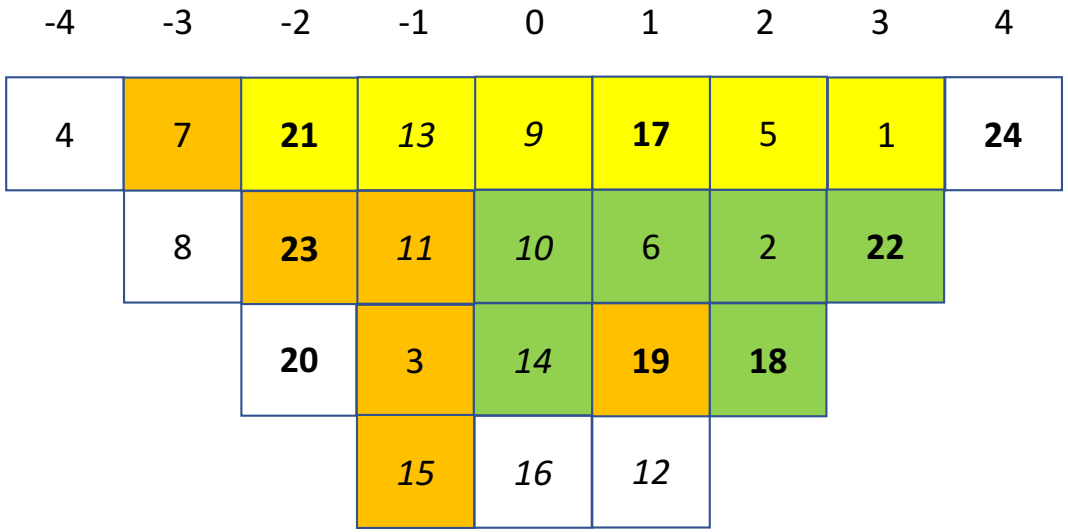


Predominant individualist and hierarchical views

Predominant advocative views

Some egalitarian views

Results

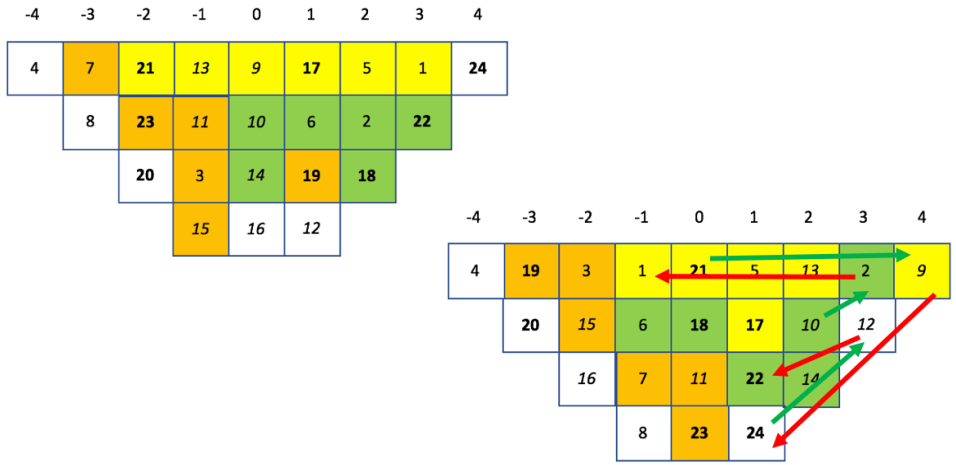


Predominant individualist and hierarchical views

2013

(s24) PRA should be also based on the voice of medical and nurse staff.
(s1) PRA serves to recognize what I am worth.
(s22) PRA should be based on more challenging goals.

Results



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(s9) PRA makes my work more responsible and self-directed.
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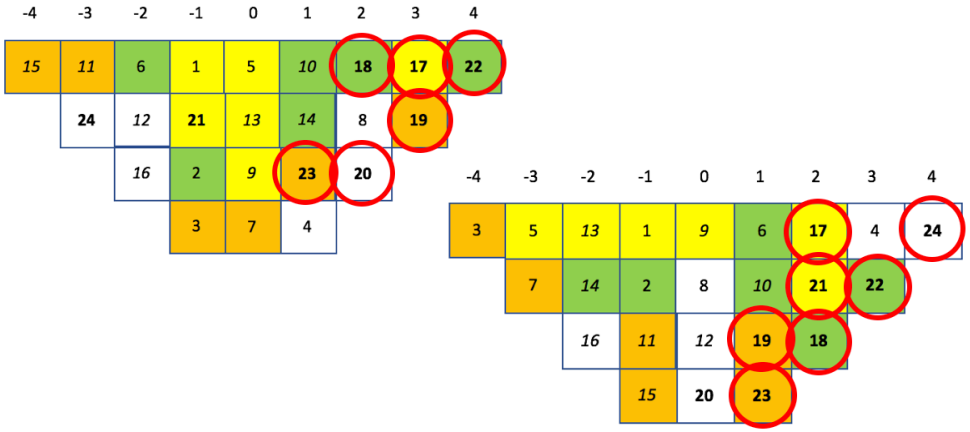

Predominant advocative views

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(s22) PRA should be based on more challenging goals.
(s17) PRA should be based on specific criteria for each type of job profile.
(s19) PRA should avoid creating tensions and rivalries between colleagues.

2016

(s24) PRA should be also based on the voice of medical and nurse staff.
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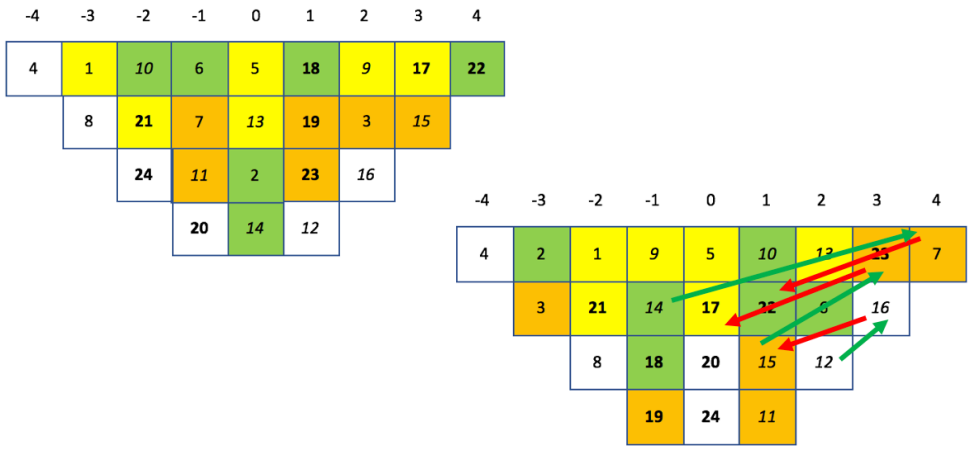

Some egalitarian views

2013

(s22) PRA should be based on more challenging goals.
(s17) PRA should be based on specific criteria for each type of job profile.
(s15) PRA makes everyone feel part of the organization.

2016

(s7) PRA serves to create a climate of collaboration.
(s23) PRA should be based primarily on indicators of group performance.
(s16) PRA is ineffective to improve services for patients.

Conclusions

RQs: How do physician executives (aka doctor managers) understand PRA? Do their attitudes towards PRA change over time?

- In part, the views towards PRA among physician executives remained consistent over time
  - Attitudes are relatively persistent, especially if value-loaded
- In part, after three years the views came to include stronger critical tones on the ineffectiveness of PRA to motivate and stimulate individuals and to improve services for patients, and on the bureaucratic and formalistic nature of PRA practices

Conclusions

- PRA is often questioned in professional organizations like healthcare because of the conflict between professional and managerial “logics”
- Attitudes of physician executives towards PRA are relatively persistent over time
- Doing PRA may not result in greater acceptance of PRA; rather, more critical tones may arise over time
- Performance appraisal of physician executives is an inherently political arena whose legitimacy needs constant institutional work to prevent critical arguments to undermine it