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Performance management in healthcare: a critical analysis

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Abstract

Purpose – The purpose of this paper is to explore the underlying theoretical assumptions and implications of current micro-level performance management and evaluation (PME) practices, specifically within health-care organizations. PME encompasses all activities that are designed and conducted to align employee outputs with organizational goals.

Design/methodology/approach – PME, in the context of healthcare, is analyzed through the lens of critical theory. Specifically, Habermas' theory of communicative action is used to highlight some of the questions that arise in looking critically at PME. To provide a richer definition of key theoretical concepts, the authors conducted a preliminary, exploratory hermeneutic semantic analysis of the key words "performance" and "management" and of the term "performance management".

Findings – Analysis reveals that existing micro-level PME systems in health-care organizations have the potential to create a workforce that is compliant, dependent, technically oriented and passive, and to support health-care systems in which inequalities and power imbalances are perpetually reinforced.

Practical implications – At a time when the health-care system is under increasing pressure to provide high-quality, affordable services with fewer resources, it may be wise to investigate new sector-specific ways of evaluating and managing performance.

Originality/value – In this paper, written for health-care leaders and health human resource specialists, the theoretical assumptions and implications of current PME practices within health-care organizations are explored. It is hoped that readers will be inspired to support innovative PME practices within their organizations that encourage peak performance among health-care professionals.

Keywords Professionals, Philosophy, Health care, Quality management, Human resource management, Habermas, Critical theory

Paper type Conceptual paper

List of Abbreviation

PME = Performance management and evaluation

On the surface, the concept of performance management and evaluation (PME) in the context of work is straightforward. Noe *et al.* (2006, p. 193) in *Fundamentals of Human Resource Management* define PME as: "the process of ensuring that employees' activities and outputs match the organization's goals". PME, although often considered to be interchangeable with performance appraisal, encompasses all activities designed and conducted to align employee outputs with organizational goals. PME activities, according to Noe *et al.* (2006), fit into one of the three categories:

(1) *Defining performance*: as in the creation and communication of expectations.

(2) *Measuring performance*: as in the development and maintenance of systems that measure output and monitor compliance with expectations.

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(3) *Providing feedback on performance*: whether formal or informal, objective or subjective.

These activities take place in all industries, including healthcare.

In defining and operationalizing the concept of performance management without discussing why this term may be relevant to the reader, Noe *et al.* (2006) were not explicit about assumptions and beliefs that may have been internalized by readers of an introductory human resource textbook. Underlying assumptions and beliefs are rarely spelled out in this context. McKenna *et al.* (2011, p. 152), while commenting on the positivist nature of existing, mainstream performance management texts and literature, state that "there is an assumed connection between PME systems and organizational performance, the validity of PME itself is never questioned".

Do members of Westernized societies equate being employed with being managed? If so, then what are the historical and philosophical impacts of such widespread acceptance of "management"? What future impacts might we expect? From early childhood, we learn that being individually evaluated and assessed is not optional. In Canada, participation in the education system is mandatory from 5 to 16 years of age. All but a small population of home- and un-schooled children spend their weekdays in a school environment. Children are taught that their teachers will have the authority to evaluate their performance and determine whether or not they have successfully acquired the skills and knowledge they are "supposed" to have acquired. Whether we choose to enter the employed workforce or pursue further education after high school, we are in for more of the same. For all but the self-employed, whose success is determined by the market, it is implicit that we will be evaluated on our performance, and that impactful decisions about our future will be made based on those evaluations.

Adding to the complexity of micro-level (individual) PME in healthcare are two discrete institutions that have an interest in overseeing the performance of each employed health-care professional:

(1) their regulatory body; and

(2) the organization employing them.

Self-regulation is, in fact, a hallmark of a "profession" versus an "occupation". The legislated mandate of regulatory bodies for health professions is to protect the public. This is accomplished through monitoring and enforcing agreed-upon standards for entry-to-practice and continued competence. Common authorities delegated by governments to regulatory bodies include:

- to create and monitor requirements for entry-to-practice;
- to monitor members' continued competence;
- to investigate complaints against members; and
- to discipline members who fail to meet the agreed-upon standards.

Delegation of these authorities to regulatory governing bodies is considered appropriate as professional peers share a specialized knowledge with the members of the association (Leslie, 2012). It is taken for granted that those certifying a professional as competent to practice can fully appreciate all contexts and situations in which an individual's competence may be tested (Davis, 2005). There is little in the literature to enhance our

understanding of how, or if, regulatory bodies and employing institutions work together or in tandem to ensure the competency of individual health professionals. In exploring disciplinary action within the nursing profession, Raper and Hudspeth (2008) report that the majority of complaints to nursing regulatory bodies are made by nursing administrators, who share evidentiary information they have gleaned through their own investigation of the problem with the regulatory body. Nurse administrators will, ideally, have a thorough understanding of disciplinary proceedings (Raper and Hudspeth, 2008); such in-depth knowledge of disciplinary processes is not typically required of a staff nurse.

Individual-level performance management is, in this light, a "permanent" aspect of the lives of health-care professionals. Current societal ideals and institutions, such as governments and universities, contribute to the permanence of this system. Critical theorists, however, remind us that what may seem permanent does not reflect a global normative constraint (Bohman, 2013), but rather the history of the institution and the beliefs and values of the people that built and sustained it.

Individual performance appraisals, a key component of most PME systems, were utilized as early as the third century. The Wei Dynasty, in China, employed an Imperial Rater who was tasked with evaluating the performance of labourers (Coens and Jenkins, 2002). The Jesuit Society, as directed by founder Ignatius Loyola, established a formal member rating system in the sixteenth century (Armstrong, 2009). In the early nineteenth century, "merit rating" systems were being used both in industry, as by Robert Owen, a Scottish cotton miller, and in the US military (Coens and Jenkins, 2002). The US military employed the WD Scott scale in their evaluation of officers; Scott was heavily influenced by Frederick Taylor's conception of scientific management. The WD Scott scale supplanted a system of promotions based on seniority, thus initiating an era of merit-based performance appraisal. Modern "results-oriented" appraisals of performance originated first in the 1970s, paving the way for the development of performance management systems, which were recognized in the late 1980s (Armstrong, 2009). We differentiate organizations in the public sector from their private sector counterparts – organizations in the public sector generate the majority of their income from government, and are accountable to multiple stakeholders; generally speaking it is more difficult to identify, in public organizations, the bottom line against which performance can be measured (Boland and Fowler, 2000).

In modern societies, fiscal crises and a shortage of financial and human resources have led to a shift in the way that public sector institutions are managed (Halachmi, 2005). Boland and Fowler (2000) argued that performance management in the public sector was "still in its infancy (or at least, its adolescence)" (p. 418). Many publicly run institutions, including health-care organizations, are increasingly governed and evaluated based on market theory and capitalist strategy (Bohman and Rehg, 2014). Many of the commonly used performance measures in the public sector are expressed with reference to budget, cost and staffing levels (e.g. cost per case, cost per service) (Boland and Fowler, 2000). Fiscal management, in general, aims to reduce uncertainty and maximize efficiency, which is why inputs and outputs are meticulously measured and tightly controlled. It is difficult in the public sector, however, to be certain that increasing the measurement of or number of outputs will result in societal needs being met – particularly when many of the benefits of interventions are not observed for many years (Boland and Fowler, 2000; Smith, 1995). Fryer *et al.* (2009) reviewed the public

sector performance management literature, and found that many researchers have concerns about trade-offs faced by public sector organizations – pursuing short-term goals in lieu of long-term goals can have negative effects on quality and, in healthcare, yield life-threatening consequences. As an alternative, researchers suggest that in public sector organizations, where quality of care is of key importance, targeted long-term goals and mission statements be used to guide the organization to reach quality goals (and not performance measurement).

In for-profit business, the consumer is king; this is not typically the case in a publically provided health-care system, where care providers have definitive ideas about when, where, why, how and if a treatment should be offered. "Patient compliance" is of high importance in healthcare, as evidenced by the 57,750 results returned following a November 2014 search of the term in the Medline database. Managers of front-line health-care staff may find themselves working together with their employees to determine how best to "manage" the consumers of health-care services. Ultimately, both the multi-disciplinary nature of modern healthcare and the asymmetry of information (Mooney and Ryan, 1993) – that is, the imbalance of medical knowledge between health-care providers and their clients – give rise to clients that are not prepared to effectively evaluate the performance of individual professionals providing their healthcare (Mooney and Ryan, 1993; Leslie, 2012; Smith, 1995). The use of online sources of health information by patients has led to a shift in the balance of informational power (Cline and Haynes, 2001); a change that, over time, *may* make consumers of healthcare better judges of the service provided to them by a diverse group of health professionals. However, studies evaluating the quality of health information available to consumers on websites have concluded that information quality (including comprehensiveness and accuracy) is mixed. As a result, patient reliance on the Internet for health information can promote unintentional misapplication of information (Schulz and Nakamoto, 2013). Ultimately, ready access to too much "knowledge" (of variable quality) may, in fact, widen the knowledge gap between health professionals and patients([1]).

Health-care professionals are presented to their clients as "experts". Profession-specific preparatory programs guide students in "becoming" nurses, dietitians or social workers (among others). Dickoff and James (1968) in their seminal paper, *A Theory of Theories: A Position Paper*, offer this definition of a professional:

> A true professional as opposed to a mere academic is action-oriented rather than being a professional spectator or commentator. But a professional as opposed to a mere technician is a doer who shapes reality rather than merely a doer who merely tends the cogs of reality according to prescribed patterns (Dickoff and James, 1968, p.199).

In this paper, we use critical theory to explore the underlying theoretical assumptions and implications of current micro-level PME practices, specifically within health-care organizations. In particular, we draw on the work of Jürgen Habermas, an influential German philosopher (Bohman and Rehg, 2014). Using Habermas' theory of communicative action highlights some of the PME-related questions that employees, managers, "naturalistic" observers and critical observers may pose. Next, through a preliminary, exploratory semantic analysis, we explore the etymology of key terms and reflect on how the evolution of the terms and their usage over time can be related to current micro-level PME practices. In critically exploring PME at the level of the individual health professional, we aim to initiate a dialogue and a process of

self-reflection within the community of health human resource researchers, policymakers and health services executives about existing PME processes.

Critical theory

Critical theorists argue for the duality of the critical approach: a thorough critical analysis of a topic will not only generate a description of all relevant contextual factors but also provide a realistic alternative to the status quo (Bohman, 2013). Philosophy, as a discipline, acknowledges limitations in human cognitive and perceptual capabilities (Repko, 2008); therefore, attempts to identify and describe all relevant contextual factors will be unavoidably flawed. Despite its inherent limitations, a critical approach, as applied to this question, helps to raise more "questions about the functions of PME and whose interests it represents" (McKenna *et al.*, 2011, p. 154). Ultimately, the critical ontology aims to defamiliarize that which is hegemonic – that is, to expose words and ideas that reinforce the status quo. This ontology highlights the ways in which existing processes entrench the control and power exerted by an organization. Critical approaches attempt to uncover the ways that identity and subjectivity are constructed through power to enhance apathy, compliance and dependence within (in this case) the workforce, "while purportedly building trust, commitment and empowerment" (McKenna *et al.*, 2011, p. 151).

By adopting a critical approach, we are taking the stance that PME may need to be rejected entirely. Does PME exist only to reinforce mainstream performance expectations, as expressed through organizational metrics of profitability (McKenna *et al.*, 2011)? If so, is this in line with the traditionally altruistic goals of health-care organizations?

The assumptions underlying PME are that employees require their performance to be managed; PME leads to improvements in employee performance; and PME assists the manager in detecting and/or correcting poor performance. We say assumptions because they have not been definitively proven as true. Such assumptions are difficult to prove empirically; in Westernized societies, to remove any and all forms of performance management within the context of the workplace would be impracticable for two reasons. First, performance management is built into the structures of our workplaces. The title of manager or supervisor, when applied to someone whose portfolio includes only human capital, strongly implies that one of the primary duties is performance management. The need for managers of regulated health-care professionals to manage employee performance is mitigated by the expectation of self-regulation by both individual members of regulatory bodies and of regulatory bodies, as entities. Lizarondo *et al.* (2014) concluded, based on a systematic review of literature related to performance evaluation among allied health professionals, that the perceived key roles of performance evaluation in healthcare were to obtain accurate insights about quality of care and to promote improvements in the delivery of health services (inclusive of administration, financial and operational management). According to Arcand and Neumann (2005), the performance management process creates and maintains the structure required to keep supervisors accountable for ensuring that their staff can competently provide safe care to patients. The second reason is that in the context of healthcare, where protection of the patient is of utmost importance, it would be difficult to justify the removal of all forms of performance management in even a single arm of an experimental trial.

To date, critical analyses of PME have developed from the *structuralist* and *post-structuralist* traditions. The broad premise is that PME is used by those in power to control their human resources, such that a measure of inequality is maintained in the workplace and in society as a whole. Structuralism specifically emphasizes the degree to which power (and thus control) is embedded within our institutions – leading to pervasive inequalities and power imbalances (McKenna *et al.*, 2011). The most tangible representation of institutional power for those in the health-care workforce is the employee's permanent file. Few employees see their own permanent file, which is typically held off-site by human resources. An employee's file contains documentation of performance evaluations, awards and recognitions and of disciplinary action taken. The contents of the employee file, that is, what can and cannot be kept within it, are dictated both by collective agreements (in unionized settings) and relevant legislation [e.g. Freedom of Information and Protection of Privacy Act (Government of Alberta, 2005)]. The file's contents significantly affect institutional promotion and/or termination decisions.

Post-structuralism posits that power is not contained within our institutions; it is, instead, embedded within our interactions – revealing itself equally in the social microcosm as in the macrocosm. Post-structuralists would view the employee as a dependent entity, unconsciously participating in their subordination to management (McKenna *et al.*, 2011).

Instigating change

Different ways of thinking about communication may guide both employers and employees to more effectively resist or challenge powerful words and ideas. Habermas, a second-generation critical theorist, in his theory of communicative action, outlines his conception of the function of philosophy, specifically in relation to the social sciences (Bohman and Rehg, 2014). The theory, and by extension, Habermas, distinguishes between a "system" exemplified by a bureaucracy or a market and a "lifeworld", which incorporates all contexts, background resources and spheres of social action in which actors cooperate based on mutually understood institutional orders, cultural systems and personality structures (Habermas, 1987; Bohman and Rehg, 2014; Thomassen, 2010). The communicative action taking place within a "lifeworld" serves to reproduce it; however, problematic key messages or ideas ***can*** be challenged incrementally, such as through the "perspective-taking" method of analysis (described below) (Thomassen, 2010). Within scientific institutions, such as health-care facilities, the existing lifeworld has been accepted as rational, such that many of the "normalized" beliefs and actions of actors within it, including those related to PME, are not questioned.

"Perspective-taking" is a way of uncovering and analysing ideas and practices that remain unquestioned. The first- and third-person perspectives are most familiar to us. When adopting the first-person perspective, one attempts to reconstruct the agent's reasoning process (Bohman, 2013). Those taking the first-person perspective in an analysis of micro-level PME in healthcare would be taking the position of the front-line clinician or the manager/supervisor, who are both personally invested in the process and its outcomes. A front-line clinician may question, among other things, how their performance is being measured and whether or not their concept of quality work matches with that of their supervisor's. A manager or supervisor may question, among other things, how their assessment of their employees' performance may reflect on their

own supervisor's perception of their work and how they can most effectively provide critical feedback without introducing strain into their relationships with employees.

The third-person perspective or explanatory viewpoint is preferred by naturalists-those who hope to remove themselves from the process of observation (Bohman, 2013). In adopting this perspective, one gives voice to the underlying hegemonic beliefs of the dominant culture – accepting as fact that Western "truths" of efficiency and order are good and waste and chaos are bad, that certain types of behaviour are appropriate in the workplace and others are not. It is not for the third person to question the premise that evaluation is necessary or effective, because this is an accepted truth. Questions asked from this perspective include: Are the public being protected from "bad" practice? Do current incentives and disciplinary actions promote desirable workplace behaviours and discourage undesirable ones?

A final perspective, the "second-person", utilizes the expertise of a participant in the discourse. As an alternative to the oppositional perspectives of the first and third person, it allows for "mutual perspective-taking". The critic, in this case, must not only interpret the attitudes, beliefs and practices of the agent, but also evaluate them as being either correct, incorrect or questionable (Bohman, 2013). As a perspective, second person is not inherently radical or prone to cultural misunderstanding; rather, it seeks to create a dialogue where one may not exist (Bohman, 2000). Questions asked from this perspective include: Are there other ways to encourage employees to produce outputs that align with organizational goals? Do health-care professionals need to be managed or are they capable of self-management? See Table I for a summary of guiding questions from the first-, third- and second-person perspectives.

Among social scientists, the naturalist approach, which prioritizes the third-person perspective, is rejected in favour of the interpretive, anti-reductionist approach. This approach favours first- and second-person perspectives on phenomena. Looking at a phenomenon from multiple perspectives and then coordinating the knowledge acquired from adopting each point of view allows for the most comprehensive analysis. Simply put, no single perspective can adequately inform a critical inquiry (Bohman, 2013).

Semantic analysis

We have conducted a preliminary, exploratory semantic analysis of the key words "performance" and "management" and of the term "performance management". The purpose of the semantic analysis was to provide a richer definition of key theoretical concepts (Sivonen *et al.*, 2010) within PME, which, in turn, enhanced our capacity to conduct an in-depth critical analysis of individual-level PME practices in healthcare. In choosing source materials for definitions and synonyms of key terms, we deliberately selected mainstream sources, such as the Oxford Dictionary of Current English (2005) and the Oxford Canadian Thesaurus of Current English (2006). The definitions and synonyms offered in these texts are reflective of the tone of mainstream business literature and elementary business textbooks – that is, the types of literature most accessible to managers in the health-care system. Sivonen *et al.* (2010), in their methodological paper describing hermeneutic semantic analysis, as conceptualized by Peep Koort, identify the four key steps required to conduct an in-depth, comprehensive semantic analysis of a key concept or word. For our purposes, we completed the first two steps:

Table I. Guiding questions from the first-, third- and second-person perspectives

First person Front-line clinician	Manager/supervisor	Third person Naturalist	Second person Participant in the discourse
How is my manager/supervisor assessing my performance?	How can I objectively measure the performance of my staff? Do existing measures reflect the quality of patient care?	What is truly being measured when we measure "performance" in healthcare?	Are health-care organizations staffed to allow for the valid evaluation of each employee's performance (assuming this is even possible)?
Does my manager/supervisor's concept of high-quality work match with mine?	Do my ideas of good performance match with those of the organization I work for?	Are the public being protected from "bad" practice?	Does evaluating performance based on the goals of the organization imply that the goals of a health-care professional change depending on where they are employed?
Does my manager see me holistically–as a person–or as a "resource", whose output is to be maximized?	If I consider the personal circumstances of my employees when measuring their performance, do I risk being accused of favouritism?	Can numbers truly capture the provision of care to a patient or client by a skilled professional?	Is the PME process having the desired effects in real-life circumstances? Would PME produce the desired effects in ideal circumstances?
Is my manager willing to accept feedback on their performance?	How do I effectively provide critical feedback without introducing strain into my relationship with my employees?	How does the relationship of the evaluator and evaluatee impact on the process of PME?	Are there other ways to encourage employees to produce outputs that are aligned with organizational goals?
Are rewards and punishments doled out based on the results of the evaluations?	Will I be penalized for perceived poor performance on the part of my employees?	How are rewards and punishments incorporated into the PME process, if at all? Do the rewards and punishments promote desirable behaviours and discourage undesirable ones?	Do health-care professionals need to be managed or are they capable of self-management?

(1) reflection on the words and concepts central to PME; and

(2) investigation of the etymological meaning(s) of words and concepts central to PME (Sivonen *et al.*, 2010).

Performance: capacity versus empathy

According to the Oxford Dictionary of Current English (2005, p. 616), "performance" describes:

> […] the act or process of performing; an act of performing a play, song, concert, etc.; a person's achievement; a fuss (*informal*); the capabilities of a machine; the return on an investment.

Synonyms include: presentation, staging, rendering, interpretation, functioning, capacity, potential and capability (Oxford Canadian Thesaurus of Current English, 2006). If "performance" in the phrase "performance management and evaluation" is replaced with the synonym "potential", then it reveals how the role of a manager could be seen as equivalent to "harnessing" an employee's potential. Being harnessed may not be an entirely pleasant experience. It evokes an image of constraint, wherein freedom must somehow be traded to fulfil one's purpose. Although health professionals do not typically work on a stage, they do have to perform to effectively do their job. The emotional labour involved in health-care work, in which events may quite literally be life and death, demands performances of health-care providers. For example, when providers feel tired and frustrated with a client, they may decide that what a client needs most is to see them as being hopeful and impressed by their progress – this involves acting.

"Acting" – reflects Dickoff and James' (1968) notion of the "action-oriented professional". In *The Theory of Social and Economic Organization,* Weber (1947) sets out to define action in the context of sociology and social action. Included within action is "all human behaviour … it may consist of positive intervention in a situation, or of deliberately refraining from such intervention or passively acquiescing in the situation" (Weber, 1947, p. 88). Action is social in that each person attaches a subjective meaning to their own actions based on the behaviour of other people (Weber, 1947). Thus, we see that "action" includes both the choice to act and the choice not to act, and that each person's action is, in part, regulated by the actions of others.

When trying to interpret an action, it is helpful for an interpreter to put him or herself in the place of the actor, thereby sympathetically participating in his or her experience. In this way, the interpreter has the best chance of grasping the emotional context within which the action occurred (Weber, 1947). The German word *verstehen* captures Weber's meaning well – it is a term that describes "understanding based on empathy" or "knowledge from within rather than from without" (Gabriel, 2009, p. 2). In the context of PME, managers are tasked with judging the appropriateness of their employees' actions. In healthcare, the context can be particularly emotional: if we accept Weber's view that acting empathically aids in interpreting others' actions, then health-care managers do well to remember that actions are best interpreted in context and with empathy.

Not all synonyms of "performance" account for the emotions of the actor – a more technically relevant group of synonyms is epitomized by the word "capacity". An insentient machine or system of connected machines can be tested to determine optimal output – from then on, performance is compared to this threshold or benchmark. In the

health-care setting, benchmarks may be set around staffing levels per patient day for a particular patient group or number of clients seen per day. This type of standard setting, for evaluative purposes, has been practiced for a long time in healthcare (Pantall, 2001; Wait and Nolte, 2005). The question is – is it practical to expect machine-like consistency from a sentient workforce that grows, evolves and sometimes burns out? More importantly, is it ethical to do so? We would argue that this expectation is neither practical nor ethical. Setting unattainable performance standards will only result in the continuous classification of performance as sub-par and a defeatist attitude among staff.

In essence, benchmarking is a way of operationalizing capacity; its system of metrics allows government and health-care administrators to make comparisons across units, facilities and organizations. Benchmarking can be approached in one of the two ways; the first relies on quantitative data and the second on the systematic analysis and comparison of existing processes and practices (Pantall, 2001). When standards used in health-care planning and evaluation are based solely on quantitative benchmarks, we end up with a system that cares little for qualitative aspects of health-care services (Pantall, 2001; Wait and Nolte, 2005). A focus on best practice and maximum efficiency drives governments and health-care executives to dictate quantifiable expectations and goals, but fails to account for and acknowledge the complexity of health-care services and the importance of contextual factors. A results-focused environment allows little room for the intangible, the unexpected or the truly innovative – factors which some would say form the basis of quality, person-centered healthcare.

Management: control versus guidance

The origin of the word "management" can be traced back to the Italian *maneggiare* and the French *manège*, which were used to describe the process of training a horse. Horse training is, in essence, a process of taking something wild and feral and transforming it into something that will be of use to humans. At first, this process of domestication may be perceived as achieving control over the animal – but to effectively tame an animal, one must treat it with respect and care. A horse trainer identifies the unique strengths and attributes of each animal, and matches them to jobs and tasks where they are most likely to succeed (Gabriel, 2009). The recipient of this "management", in the case of the horse, is presumed to be motivated by extrinsic rewards, such as food and praise.

Today, "management" is more likely to be heard in a boardroom than a barn. The Oxford Dictionary of Current English defines management as "the action of managing; the managers of an organization" (2005, p. 500). Gabriel's (2009, p.172) definition is more descriptive: "to plan, organize, lead, coordinate, and control". These synonyms of management[2] fall into one of the two general categories – hard and soft. "Hard" synonyms include charge, direction, control, ruling, command and overseeing. "Soft" ones include care, guidance and leadership (Gabriel, 2009). Depending on the setting and the context of a discourse, the tone will either be "hard" or "soft".

In a more traditional business setting, "management" is more likely to be interpreted as being synonymous with control, as it is in "anger management" – a process through which an individual gains control over their anger. The concept of Scientific Management, introduced by Frederick W. Taylor during the Industrial Revolution (Encyclopedia Brittanica, 2014), defines how the technical process of production can be adapted to control performance. For example, the pace at which assembly line machinery runs determines how quickly employees must work. As we have moved from

a product-based economy to a service-based economy, we have seen how controls can be incorporated into the culture of an organization, such that workplace norms and values encourage and reward specific "desirable" behaviours. Whether intentionally or unintentionally, health-care organizations adopt and implement procedures and strategies that align with principles of behavioural conditioning – that is, incorporating both positive and negative reinforcement – to motivate employees to meet organizational goals. When expectations are incorporated into the "lifeworld", rather than explicitly enforced, "desirable" behaviours become habitual and need not be en-*forced* (Gabriel, 2009).

A primary assumption underlying behavioural conditioning is that employees, in this case health-care professionals, are extrinsically motivated – that is, they are motivated by tangible, external rewards associated with their work, and will underperform in the absence of behaviour re-enforcers. According to Smith (1995, p. 16), public management systems of that era (1990s) were predicated on the belief that public sector employees were "self-seeking utility maximizers". This assumption fails to account for the internal drive within individuals to succeed and contribute in their workplace. McCabe *et al.* (2005), in a survey of nurses, found that for many, what drew them to the profession were intrinsic rewards, such as the opportunity to work closely with others, the ability to assist others in need and an interest in challenging, interesting work. A recent systematic review found that five factors associated with nurse leadership had a significant impact on nurse performance: autonomy, working relationships, access to resources, individual nurse characteristics and leadership practices (Brady Germain and Cummings, 2010). Evidence exists to support the effectiveness of extrinsic motivators in improving performance on technical tasks; however, creativity, a product of complexity and cognitive flexibility, is most evident when intrinsic motivation is strong (Amabile, 1993). The practice of providing healthcare is often described as both an art and a science (Dole and Nypaver, 2012). When resources are scarce, incremental technical efficiencies may not solve the problem: in these times, creativity may be of the most use. Among the key lessons identified following a Canadian program targeting Social Innovation Generation was that conventional methods of evaluation, which compare outcomes to pre-set objectives, can inhibit innovation. Innovation depends on risk-taking, freedom to fail and experimentation among would-be innovators (The J.W. McConnell Family Foundation, 2014).

PME systems are designed to transmit the performance expectations of the organization to employees, who then internalize them (McKenna *et al.*, 2011). In essence, a PME system functions to "create, define, and enforce an identity on employees while they are at work" (McKenna *et al.*, 2011, p. 154; Barratt, 2002). Buildings and spaces can serve similar functions – hospitals are designed to optimize visibility of patients to staff (and, correspondingly, of staff to management). Enhanced visibility is seen as enhancing quality, efficiency and effectiveness of care (Reiling, 2006).

Performance management: scientific versus tactical

Aubrey Daniels, who coined the term "performance management" in the late 1970s, defines it as "a way of getting people to do what you want them to do and like it" (Aubrey Daniels International, 2014). Drawing on our etymological analysis of "performance" and "management", we can see that Daniels seems to be equating "performance" to

"acting" and "management" to "control": a rather frightening combination. On his website, he states that performance management cannot be reduced to organizational hierarchy, performance reviews or empty praise. It is, rather, a "scientific approach to managing behaviour" that finds its roots in behaviour analysis (Aubrey Daniels International, 2014). Because the term was first used more than 30 years ago, it has been implanted firmly in the business vernacular. Typically, the term is used to describe all functions performed by the human resources department of an organization that target existing staff (Aubrey Daniels International, 2014).

Discussion

In sum, existing PME systems in health-care organizations have the potential to create a workforce that is compliant, dependent, technically oriented and passive, and to support health-care systems in which inequalities and power imbalances are perpetually reinforced. This is particularly concerning, when considered alongside increasing demands upon health-care systems to increase the accessibility and affordability of health-care services with fewer resources and greater accountability (Lizarondo *et al.*, 2014). By adopting a second-person perspective, and thereby evaluating the underlying hegemonic beliefs that form the basis of our acceptance of micro-level PME systems, policymakers and health administrators may discover alternative ways of achieving organizational goals that do not rely on a submissive workforce. One possible alternative method for PME comes from the technological sector. Google staff, according to the 2004 "Owners Manual" for shareholders of the company, are encouraged to spend 20 per cent of their work time identifying, developing and experimenting with projects they feel will most benefit Google; Google maps and Gmail were both results of "20 per cent time" (Page and Brin, 2004). In the health-care sector, employees could be encouraged to spend a certain percentage of their time working on projects they feel will most benefit clients, patients and residents, regardless of whether the projects fit within the organization's strategic plan. These projects would not be subject to evaluation, giving employees the freedom to fail. In this way, employees may surpass organizational expectations and bring about system change.

In exploring the origin of key terms, it is possible to see how multiple meanings are attributed to both "performance" and "management", and yet "performance management", as defined by Daniels, only partially captures those meanings. The term is, undoubtedly, less than the sum of its parts. It fails to incorporate the artistry of "performance", which, in healthcare, can apply to the demonstration of clinical intuition (often in life and death situations) by a health-care professional; this capacity to act beyond guidelines and metrics, to provide a quality of care that cannot necessarily be quantified and measured, is what separates people from machines. Daniels' definition also fails to incorporate meanings of "management" associated with leading, guiding and empowering employees (for reasons other than getting them to do what you want them to do). We posit that the inherent reductiveness of the term "performance management" has, in part, led to a reductive approach to human resources management. Just as the richness and depth of the component words ("performance" and "management") remain unrecognized, so does the richness and depth of individual employees within an organization.

A reductive interpretation of "performance management" inherently leads to negative assumptions about employee motivation. Why should individual-level PME

continue in healthcare, when it is clear that health-care providers are intrinsically motivated? Adopting a "20 per cent Time" policy, or something similar, would demonstrate trust in employees and recognize their capacity to create and act effectively in the absence of step-by-step directions and near-constant monitoring, without risking the potential consequences of total professional freedom, such as could result from a complete absence of PME.

In general, existing criticisms of PME (McKenna *et al.*, 2011) boil down to the hegemony of positivist ideology. The premise is that PME is based on science and that through science (as seen through a positivist lens[3]), we can learn how humans will behave when they are exposed to certain types of emotional stimuli. By applying this science in the management of employees, we can get them to do what we want them to do (McKenna *et al.*, 2011). Assuming this is true – is this what society needs? We propose that patients, clients and communities-at-large would prefer that care providers do *more* than fulfil the potentially arbitrary expectations of their supervisors and managers, who may or may not have any clinical experience. An additional benefit of a Google-esque "20 per cent Time" policy may be that health-care employees produce improvements in health outcomes that exceed those perceived as feasible (via standard practice) by organization leaders.

The idea that formal, modern PME practices are irrelevant in the "post-positivist work environment" (McKenna *et al.*, 2011, p. 152) is worth exploring. PME systems lend themselves to work environments, where tasks are mechanically performed and job duties are clearly defined (McKenna *et al.*, 2011). Health-care professionals are dually accountable to their employer(s) and to their regulatory body (which is, in turn, accountable to the broader public). They must be flexible, constantly adapting to patient needs and to evidence supporting (or failing to support) treatments they provide. Within health-care environments, a standardized process and system of micro-level PME is unlikely to produce the best results or to inspire health-care professionals to perform at their peak. Ethical issues, frequently encountered in the health-care system, are not easily (or appropriately, in some cases) addressed using a standardized process or template. It may be for these reasons that Lizarondo *et al.* (2014), following their systematic review of the literature related to performance evaluation among allied health professionals, concluded that meso-level assessment of small functional groups more effectively contributed to professional performance and the effectiveness of the team than micro-level performance evaluation.

Of course, before asserting the validity of these recommendations, our criticisms of the PME system must be reviewed and evaluated, both by regulatory bodies and by organizations and individuals using PME practices. This is a key part of the critical inquiry process (Bohman and Rehg, 2014). As such, the true purpose of this critical inquiry will only be served when it has been read, discussed and (yes) evaluated from all perspectives.

Limitations

In this paper, we address neither all factors that may affect selection of a micro-level PME system, its effectiveness once implemented, nor issues or effectiveness of measuring quality and ensuring accountability at meso- or macro-levels. We neither include an in-depth discussion of historical changes in the medical and paramedical professions nor explicitly discuss how a move to interdisciplinary models of care may

impact upon the validity or practice of PME in healthcare. An in-depth discussion of the influence of politics (governmental, institutional and unit-specific) on ways in which PME is enacted in a health system is also beyond the scope of this paper. Conceptually, we think the issues with PME can apply in many countries, but we acknowledge that empiric literature cited primarily reflects experiences with PME in the Western world (North America, Europe, Australia). The semantic analysis presented is preliminary and exploratory – a comprehensive, in-depth hermeneutic semantic analysis of all key terms would be a valuable addition to the literature.

Conclusion

Existing individual-level PME systems in health-care organizations are neither designed to support innovative practice nor foster environments characterized by power-sharing among managers, supervisors and their staff. At a time when the health-care system is under increasing pressure to provide high-quality, affordable services at a lower cost, it would be wise for health-care managers to provide employees with the freedom to create new ways of doing things – including new ways of evaluating and managing performance.

Notes

1. See Hordern *et al.* (2011) for a comprehensive discussion of consumer e-health and its implications.
2. Gabriel's (2009) definition of management aligns well with managerialist ideology, advocated for in the private sector for well over 30 years (O'Reilly and Reed, 2010). O'Reilly and Reed (2010, p. 962) define managerialism as "a belief in the importance and efficacy of management as a system of organizational co-ordination". Our views on the role of "management" in healthcare differ significantly from a strictly managerialist view; our focus is on leadership and the capacity for emotionally intelligent, transformational leaders to effect positive change in their organizations (e.g. Cummings *et al.* (2010)). How different a "leadership-centred" ideology is from a "managerialist" ideology is a matter of some debate; readers are referred to O'Reilly and Reed (2010) for an in-depth discussion of "leaderism" and the evolution of managerialism in the UK public service.
3. As readers are likely aware, different lenses or paradigms are used to guide knowledge creation through science: alternatives to the positivist paradigm include interpretive and critical paradigms. However, North American PME research is, by and large, rooted in positivism (McKenna *et al.*, 2011).

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