

Knights and knaves in the English medical profession: the case of Clinical Excellence Awards

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Abstract

We elaborate Le Grand's thesis of 'knights and knaves' in terms of clinical excellence awards (CEAs), the 'financial bonuses' which are paid to over half of all English hospital specialists and which can be as much as £75,000 (€92,000) *per year* in addition to an NHS (National Health Service) salary. Knights are "individuals who are motivated to help others for no private reward' while knaves are 'self-interested individuals who are motivated to help others only if by doing so they will serve their private interests.' Doctors (individually and collectively) exhibit both traits but explanations of the inter-relationship between them have remained neglected. Through a textual analysis of written responses to a recent review of CEAs, we examine the 'knightly' and 'knavish' arguments used by medical professional stakeholders in defending these CEAs. While doctors promote their knightly claims, they are also knavish in shaping the preferences of and options for policy-makers. Policy-makers continue to support CEAs but have introduced revised criteria for CEAs, putting pressure on the medical profession to accept reforms. CEAs illustrate the enduring and flexible power of the medical profession in the UK in colonising reforms to their pay, and also the subtle inter-relationship between knights and knaves in health policy.

This paper applies Le Grand's (2003) notion of knights and knaves to the hitherto neglected aspect of (hospital) doctors' pay in England. This attention on doctors' pay is likely to reveal significant patterns of power in terms of the medical profession's strategies to anticipate and deflect external threats. Indeed, the profession may counter these challenges of reform and instead secure continued autonomy and control. One such reform (or prospect of reform) might be the 2011 government consultation regarding the future of clinical excellence awards, the financial 'bonuses' awarded to senior hospital doctors and clinical academics.

The paper is divided into five sections. The first elaborates Le Grand's thesis of knights and knaves in public service organisations, and applies this to the English medical profession. The second describes CEAs in terms of their origins, history and purpose. The third summarises the methods conducted in an empirical study of secondary data sources. Findings are presented in the fourth section in terms of key two themes: pay and income, and new professionalism. The final section offers a re-assessment of the knights/knaves thesis.

Knights, knaves and doctors

This paper draws on ideas from Le Grand's (2003) book *Motivation, agency and public policy*. The book was seminal in that its heuristic devices showed the ways in which motivation and agency were implicated in the design and implementation of public policy (Klein, 2012). It sought 'to capture policy-makers' perceptions of reality and to show how this has affected policy design' (p.17). Although Titmuss' earlier work had examined altruism and self-interest (Deakin, 1993; Deakin and Mann, 1999), Le Grand adopted metaphorical uses of notions of knights and knaves, as well as queens and pawns.

Here, we focus on the way Le Grand addressed motivation, which he defined as 'the internal desires or preferences that incite action' (p.2). He argues that both knights and knaves could be

applied to suppliers, users of services and tax-payers. But he uses these terms heuristically, a 'shorthand for describing individuals' motivations, not necessarily individuals themselves' (p.24). His conceptualisation of human agency has, however, been questioned as unrealistic by Greener (2002) who prefers Bourdieu's (1990) notion of 'habitus' as it denotes a 'set of dispositions that incline agents to act and react in certain ways' (p.691).

According to Le Grand (2003), knights are 'individuals who are motivated to help others for no private reward...' (p.26). These individuals are altruistic and public-spirited, foregoing their own interests in favour of others (at an individual or societal level). In terms of practitioners, knights have traditionally been perceived as occupational groups such as 'professionals such as doctors and teachers' (p.5). These groups were seen to be motivated by ethics and vocation, heavily influenced by professional norms and socialised into professional values (Exworthy and Halford, 1999; Freidson, 1994). Furthermore, social norms have often valued such knightly behaviour through, for example, higher incomes, status or autonomy. Le Grand notes that medicine has traditionally been illustrative of knightly behaviour rather than self-interested knavery. Examples of this include the Hippocratic oath, professional norms of working beyond contracted hours and claims of working 'in the best interests of the patient.' By contrast, knaves are 'self-interested individuals who are motivated to help others only if by doing so they will serve their private interests' (p.26). Self-interest is multi-faceted but could include financial gain (income), autonomy (freedom from external control), status and power. Given the centrality of senior hospital and academic doctors ('consultants') to the NHS, their power lies in their ability to control time (e.g., when patients are seen) and their ability to work in both public (NHS) and private sectors (with the potential to encourage patients to move from the former to the latter, where incomes are invariably higher).

This heuristic distinction between knights and knaves has resonance with debates in the sociology of professions and in human resource management. Shifts in societal attitudes towards providers of welfare have seen professionals as self-interested. Whilst doctors are still seen by the public as trustworthy (Elston, 2009), such trust has been dented by recent medical

scandals (Dixon-Woods *et al.*, 2011), some of which have questioned their altruism. Additionally, new public management (NPM), introduced by neo-liberal governments over the past 30 years, has sought to change the balance of power away from medical professionals (Ferlie and Geraghty, 2005; Harrison and Pollitt, 1994). In challenging professional power, the state (and its agents such as managers) has sought to constrain medical autonomy. The state has thus adjusted the social contract between the state and medical profession (Klein, 1990) which has perceived doctors as 'largely self-interested' (Le Grand, 1997: 158). This shift did not affect professionals alone but all those working in the public sector (Greener, 2002).

However, the medical profession has not been passive to such challenges, often adopting a strategy of re-professionalisation. This 'new professionalism' (Kuhlmann, 2006) has sought to re-frame the external challenges (such as managerialism or consumerism) and thereby absorb or deflect them (Exworthy and Halford, 1999). On occasion, the medical profession has been able to 'maintain or even enhance its autonomy and control' (Calnan and Gabe, 2009: 58). However, in order to justify this professionalising strategy, the medical profession has re-framed the criteria by which medical performance is measured and managed (Harrison and Checkland, 2009). Traditionally, doctors have been in control of setting the standards of their own work, of monitoring that work (through peer review) and of determining rewards or sanctions (Exworthy, 1998). Increasingly, doctors' work is framed in terms of evidence-based medicine (EBM) (Harrison, 2002). Whilst EBM has the appearance of external control, it is the knowledge elite of the profession which shapes the content and format of such evidence. Often, the equivocal nature of evidence lends further ambiguity to this esoteric knowledge, hampering external interpretation, minimising control and thereby preserving autonomy (Suddaby and Viale, 2011).

Here, intrinsic and extrinsic motivation can equate largely to the 'knights and knaves' distinction used by Le Grand (2003). The distinction between intrinsic and extrinsic motivation may, however, be more illusory if viewed inter-dependently. Both co-exist in policy and practice and one may have (adverse) consequences upon the other (Taylor-Gooby *et al.*, 2000). Disney

et al. (2013) refer to self-determination theory to explain this inter-relationship (Deci and Ryan, 2000). Policies which maintain the possibility of autonomy are internalized (thus enabling crowding-in) and as perceived as fair, will enhance intrinsic motivation through extrinsic means.

As Le Grand (1997) argues, it is often assumed that there will be no impact from the introduction of, say, a 'knave strategy on knightly behaviour'. Yet, it cannot be held that knights would continue as before since 'a knave directed strategy may make the knights behave more knavishly' (p.162). Le Grand (1997) presents a hypothetical argument about the introduction of performance-related pay (PRP), which is germane to the application of his ideas later in this paper. He pre-supposes that doctors are behaving in a knightly way and that they are paid a salary. He refers to a group of knavish doctors who might be 'spending time on the golf course or managing their investment portfolio'. Even though the latter group are a minority, they are damaging the hospital's reputation. He then considers the impact of PRP.

Since they are not motivated by economic self-interest, this will leave the knights' motivational structure untouched: they will still derive the same reward as before from doing good to patients.... The knaves, on the other hand, will see that it is now in their self-interest to perform their duties properly and will react accordingly. What the new structure will have done, therefore, is bring the knaves into line, ensuring that they perform as least as well as the knights (p.161).

In this case, doctors as knaves will become 'free-riders', getting paid additionally for work they would have done anyway. Yet, if financial incentives are (too closely) linked to managerial objectives, it is likely that doctors' internal motivation will be 'crowded out' by extrinsic factors (Frey, 1997; Frey and Jegen, 2001; Marshall and Harrison, 2005). Conversely, if doctors 'feel' that they 'own' the PRP scheme (the process by which they are determined and allocated), then the effect might be the opposite, a 'crowding in' effect. However, the scale and direction of the effect may be conditional upon three factors. First, doctors may have a 'reward expectancy' (Cho and Parry, 2012) which is a 'target income' to which they aspire. This may be comparable with others professions (such as lawyers or accountants) whom they see as equivalent. Second,

there might be a threshold beyond which additional income has a decreasing marginal effect (and possibly, even negative effect) upon their motivation. Thus, extrinsic motivation might be significant up to a certain threshold but, beyond that, intrinsic motivation becomes more prevalent (Klein, 2012). If the profession secures incomes beyond the threshold, it may appear that the members of the profession are solely concerned with intrinsic matters. Third, it may be that the financial amounts per se matter less than the prestige and social reputation associated with the status of a senior doctor (Frey, 2013). If so, non-financial recognition could be more applicable. This already happens somewhat in medicine, with its propensity for awards, honours and medals (Frey and Neckermann, 2009).

Yet, claims of intrinsic motivation among professionals, notably doctors, may be reliant upon a more implicit (yet powerful) expression of extrinsic motivation. Le Grand (2003) suggests that, rather than just being intrinsically motivated, public sector professions are also driven by extrinsic ideas of self-preservation, power retention and financial concerns. This has implications for conceptualising professional motivation. For example, it may be argued that the existing stratification of the profession between knowledge elite, administrative elite, and the rank-and-file (Freidson, 1994), can be aligned with intrinsic and extrinsic motivation. Whilst individual rank-and-file professionals are able to claim an on-going commitment to altruism, public-spiritedness and thus intrinsic motivation, they are equally able to eschew extrinsic motivation. Yet, the administrative elite (locally or nationally) can, at the same time, act to defend (or enhance) their members' financial interests. Similarly, Klein (2012) argues that doctors may act as knights towards their patients but as knaves towards the state. This approach helps resolve the paradox whereby doctors, whilst claiming to be focused solely on intrinsic concerns, are well rewarded extrinsically (financially and otherwise). Moreover, unlike the sociology of professions, much of the literature on motivation does not adequately distinguish between individual (micro) and collective (macro) levels. (Le Grand (1997: 167) does, however, recognise this in an endnote.)

Despite such theoretical arguments, empirical evidence on professionals is less forthcoming. This dearth might be explained by three factors. First, expressed claims about motivation may not reveal a 'true' picture given the 'halo effect' whereby respondents would be expected to display outward signs of intrinsic motivation and reject extrinsic concerns (Le Grand, 2003: 34). Extrinsic factors thus remain hidden from the researcher's gaze. Second, many empirical studies provide little corroborative evidence of motivation claims. Specifically, there is very limited evidence about actual decision-making. Third, most studies are experimental in design, focusing on manual workers in manufacturing organisations (where PRP may be easier to measure and implement) or on lab-based tests with students (Frey and Jegen, 2001). Less evident in studies are public sector professionals or the deliberations behind pay-based decisions. In health-care, studies of the Quality and Outcomes Framework (QOF; the scheme for incentivising primary care doctors) are exceptions (*eg.* Grant *et al.*, 2009). Senior hospital doctors are often overlooked in studies (*cf.* Bloor *et al.*, 2008; Le Grand, 2003; Crilly and Le Grand, 2004; Klein, 2012). Moreover, the literature of public service ethos does not usually address financial matters (Needham, 2006).

The evidence presented here points to the following research questions Do CEAs offer an insight into the motivation and behaviour of the medical profession and doctors? How does the medical profession seek to control the distribution of CEAs? Do CEAs (as extrinsic rewards) 'crowd out' any knightly behaviour? Is there evidence of knavish behaviour as a result of CEAs? These questions (drawing on Le Grand's thesis) frame the empirical study relating to the medical profession, motivation and financial incentives.

Clinical Excellence Awards – a knightly or knavish strategy?

A case-study of 'clinical excellence awards' was conducted to explore how and in what ways the medical profession acts as knights and/or knaves with regard to their pay. These awards require some description since they are not commonly discussed in UK health policy and no other country has an equivalent scheme (Capita, 2011).

CEAs were established in 1948 (under a different name – merit and distinction awards) to secure the participation of the medical profession in the fledgling NHS, whose members might otherwise be tempted to work in the private medical sector. The then health minister explained that he had to provide doctors with additional money ('stuff their mouths with gold') to secure their involvement in the NHS (Timmins, 1995: 115). CEAs were also designed to encourage individual doctors to practise in all geographical areas and in all specialities.

The awards are given to senior doctors who meet criteria across five domains, indicative of a quality of work 'over and above' contractual obligations, as determined by a system of local and national committees. (These domains include: delivering a high quality service, developing a high quality service, leadership and managing a high quality service, research and innovation, and teaching and training). Criteria for allocating awards have changed over time but since 2001, greater emphasis has been placed on 'delivering and improving local and health services.' This emphasis has been complemented by rising managerial and lay representation on award committees. However, doctors still account for 50 per cent or more of the representation of these committees; the remainder comprises managers and lay members.

The value of individual awards ranges from £3,000 (€4,065) to £75,000 (€101,000) per annum across 12 levels, which are paid in addition to basic salary (exchange rates as of May 2015). Together with CEAs, the median annual total earnings of a consultant (from the NHS) are, for 2011–12, £109,000 (€147,000) (National Audit Office, 2013). (Income from private medical practice would be additional). The awards are pensionable. They are reviewed every five years but are rarely withdrawn.

In 2013, 61 per cent of the 40,000 NHS consultants were in receipt of an award (NAO, 2013). The estimated cost to the NHS is over £500 million (€677M) per annum (National Audit Office, 2013), equivalent to the annual revenue of two medium-sized hospitals. If CEAs were to be shared equally among all consultants, this would imply an additional £12,848 (€17,409) per

consultant, representing 11.8 per cent of a consultant's salary. This proportion is much higher than the usual value of PRP schemes in the public sector which tend to be no more than 5 per cent of salary (OECD, 2005).

The economic recession since 2008 has prompted the UK government to curtail public sector pay through a freeze in pay increase of those earning over £21,000 (£28,500) per annum (up to April 2013). Earlier in 2004, primary care and hospital doctors negotiated a new employment contract with the government, which led to significant 'basic' pay increases (of 24 per cent for lower grades, rising to 28 per cent for higher grades) (NAO 2013). These did not, however, lead to commensurate rises in NHS productivity (National Audit Office, 2010). In 2013, CEAs were under review in England and Wales, were been withdrawn in Scotland, and were withdrawn and then re-instated in Northern Ireland (following judicial review by the doctors' union, the British Medical Association (BMA)). Reforms to the awards have so far tended to be marginal, removing anomalies or clarifying criteria; there has been no attempt to remove CEAs.

Methods

In order to answer the research questions regarding motivation and behaviour of the medical profession, the control of the distribution of CEAs, and the conceptual frame of knights and knaves, we examined the written accounts of the medical professional about CEAs.

A recent consultation about the future of CEAs, conducted by the Doctors' and Dentists' Review Board (DDRB) in 2010, elicited such accounts voluntarily. Perhaps for the first time, these accounts offered evidence of the medical profession's justification of CEAs and their responses to possible reforms. To date, no empirical study has been undertaken to investigate doctors' attitudes towards CEAs or the impact of CEAs upon their behaviour. This study does not examine individual doctors' views on CEAs but rather their professional bodies' defence of them which often deployed generalised statements about their members' motivation and behaviour.

The evidence submitted to the DDRB consultation is publicly available online

(http://webarchive.nationalarchives.gov.uk/20130513091446/http://www.ome.uk.com/DDRBCEA_review.aspx - accessed October 2013). Seventy-eight submissions were made from

organisations on behalf of medical Royal Colleges (bodies representing professional standards of each specialty), NHS hospitals, and the government, among others. A further 42 submissions were made by individuals. We confine our interest in this paper primarily to the 53 submissions made by medical profession bodies. The value of these submissions lies in the ways in which the profession justifies CEAs in the face of potential reform.

We downloaded the submissions and analysed the content of these with regards to their claims about the distribution of awards, the stated purpose of the awards, the value of performance-related pay, and professional power. Direct content analysis, as outlined by Hsieh and Shannon (2005), was undertaken in terms of the a priori themes (discussed earlier) and three NHS stakeholder groups (doctors, the government, and managers). Here, we focus on the first regarding pay and income, and new professionalism.

The professions' statements are not affected by researcher bias (as might happen in face-to-face interviews or participant-observation). However, such studies might be problematic in terms of access, determining doctors' actual attitude and behaviour, and ensuring adequate generalisation. Written evidence reveals little about individual doctors' attitudes or behaviour (other than those doctors who submitted evidence to the DDRB as individuals). Our analysis does not examine these accounts as evidence of doctors' motivation per se but rather seeks to clarify the ways in which the profession attempts to justify financial incentives on the basis of (intrinsic or extrinsic) motivation. Also, written statements might be rhetorical devices and not reflect the views of their members. Professional power dynamics might not be exerted through these written media but rather through more discursive practices (such as the committees which allocate CEAs).

Findings: medical pay, income and the new professionalism

Submissions from professional bodies and individual doctors were overwhelmingly supportive of CEAs. Some sought to remove anomalies, others favoured greater transparency but all sought to ensure the continuation of the scheme. Very few suggested specific reforms. It is significant that critical voices within the profession did not use this opportunity to express their concerns. One group did, however, disagree with the term 'clinical excellence':

'The term Clinical Excellence Awards is in itself misleading. There is a premise within the name that awards are dispensed to those who excel at clinical care.' (British Association of Surgical Oncology (BASO) submission, p.1).

Often, the claims made in the submissions were normative, without much empirical justification. When sources were cited, it was invariably partial, drawing on a limited range of evidence. For example, evidence from economics and psychology were occasionally cited (in the form of one or two articles) but without much critical insight.

We confine our findings to two major themes (pay and income, and the new professionalism) which emerged from the analysis.

Pay and income

Doctors argued that CEAs were a just reward (beyond basic pay) for, in their terms, their long training, long working hours, their contribution to the NHS and even the health of the nation (BMA submission). CEAs were, doctors argued, a fair way of rewarding doctors, in addition to their NHS salary.

While no consultant embarks on a service or practice-improving project solely because of the potential to receive an award, there is *no doubt* that it helps to compensate for and recognise the extra work this demands (BMA submission, para.1.121) (emphasis added).

One group justified CEAs on the basis that the scheme offered value for money compared to any alternative:

‘In terms of cost of consultants’ time, the current scheme is *clearly* cost-effective compared to commercial rates of remuneration’ (Society for Cardio-Thoracic Surgery (SCTS) submission, p.2) (emphasis added).

Both previous quotes demonstrate an apparent uncritical acceptance of the value of CEAs. Scant evidence was offered to justify these claims; comparisons (*e.g.*, commercial rates) were, for example, unsubstantiated.

Submissions sometimes referred to the costs of CEAs as a ‘small’ proportion of the overall consultant wage costs but, equally, they noted that the value of CEAs needed to be sufficiently ‘large’ to motivate doctors.

The BMA cited the ACCEA (Advisory Committee on CEAs; the government body which administers national CEAs) guide which explains that awards can be given to those who also undertake some clinical work in the private sector. However, doctors rarely mentioned the income that some of them derived from private medical care. The Royal College of Physicians (RCP) did, however, briefly mention CEAs as a ‘compensation’ for loss of potential income from private practice. (Some specialties are more likely than others to generate such private income). UK doctors are able to practice medicine in both public and private sectors, and so they do not wholly reject the latter (as the RCP implies).

‘In some situations the award is to compensate for concentrating on the NHS and rejecting remunerative private practice’ (RCP submission, p.3)

A potential migration of NHS doctors to the private sector was hardly mentioned. None mentioned a ‘crisis’ of recruitment or retention of NHS consultants even though shortages are apparent in specialties such as emergency medicine (Health Select Committee, 2013).

Doctors sought to frame their arguments about income levels in terms of comparable professions such as barristers and architects (BMA submission, table 1.5). (No comparisons were made with other clinical colleagues). The income of hospital doctors and clinical academics were also compared to those of general medical practitioners (GPs) whose income

was seen as much higher. (GPs are independent contractors and so their total income also comprises staff wages in their practice and others expenses).

The highest performing GPs receive income many times higher than consultants holding clinical excellence awards... The awards, while of high value, are, in contrast to the private sector, modest; senior company directors can expect six- and seven figure salaries (Submission by Peter Robb, ENT consultant).

Doctors' arguments sought to balance the need to maintain parity but also to ensure that doctors' pay did not become too mis-aligned with them.

'We are satisfied that, taking a long term view, the review body's data show that on average consultants are not overpaid relative to their peers' (BMA submission, para.186).

Doctors' incomes (and CEAs) were justified on the basis that doctors needed to undergo extensive training which ensured that their earning started later than others and that high levels of earnings were only reached some 15 years later.

'Most doctors will not begin paid employment until they are 23-25 years of age and will not achieve consultant appointment until mid to late 30s' (Submission by Peter Robb, ENT consultant).

Some comparisons were seen as unfavourable, notably the association of CEAs with other bonuses (e.g., bankers' bonuses have received public scorn since the 2008 financial crisis).

'It is understandable that many may regard this as equivalent to 'bankers' bonuses', and assume that consultants may, by the ACCEA scheme, simply be being rewarded for doing their jobs properly.' (BASO submission, p.1).

Submissions often referred to doctors working 'over and above' contractual requirements. Hospitals' autonomy to agree 'job plans' with consultants have complicated the local meaning of 'over and above.' The BASO submission summarises such concerns:

'Whilst some of these activities occur during the course of a normal working day and may be remunerated locally in the time allocated for supporting professional activity, many are not' (p.2).

BASO also cites the time pressures of additional work:

‘There is often little account taken of the substantial amount of preparation time these activities take and usually no account of the travelling involved and the disruption this causes to the personal life of Consultants’ (p.2).

CEAs are pensionable which can be financially advantageous to award holders. Unsurprisingly, doctors’ submissions sought to defend any changes that could be introduced.

‘There should be no reason for the review body to recommend any changes to the CEA/distinction award/discretionary points schemes for reason of pensionability’ (BMA submission, para.1.105).

Pay-for-performance (PFP) schemes in the private and public sectors were cited as justification for the (on-going) need for CEAs. For example, the British Society for Rheumatology (BSR) argued that

‘...using compensation levels above the standard pay scale is an entirely appropriate way to do it. The concept of using pay to differentiate among employees is commonplace among both public and private sector employers’ (p.2).

Some made justifications for PFP on the basis that there was evidence of improved outcomes:

‘There are a number of studies suggesting that PRP schemes have a positive influence on organisational performance’ (BMA submission, para.1.89).

New professionalism

The second theme concerned the portrayal of a ‘new professionalism’, comprising partnership with patients (rather than paternalism) and accountability and transparency (rather than autonomy and self-regulation)(Elston, 2009). In order to justify CEAs, submissions from the medical profession drew connections between intrinsic motivation and extrinsic motivation. Thus, in order to practice ethically and effectively, the doctor needed to be rewarded appropriately, it was argued.

‘To retain the concept of professionalism amongst consultant staff and senior academics, a reward system for exceptional service who perform *‘over and above’* the standard expected of their role should be retained’ (RCP submission, p.1).

However, the incentives needed to be maintained and continually reinforced, according to doctors.

‘A lack of recognition of excellent work was likely to result in consultants concentrating primarily and possibly solely on core responsibilities’ (BMA submission, para.1.115).

The RCP reinforced this point by noting the need to recognise a consultant’s ‘aspiration to progression throughout their career (p.2). The BMA raised the prospect that reform of CEAs might even lead to a ‘two tier’ consultant system (para.1.116). Indeed, their argument went further; CEAs were essential to ensuring adequate incentives for doctors to practise.

It is hard to see how consultants will be willing or even able to continue doing some of the additional work that they undertake which supports the wider objectives of the NHS... without a mechanism that encourages them to work more intensively and innovatively in their ordinary working day, but also acknowledges the work done in their own time (BMA submission, para.1.117).

Frey (2013) argues that many workers claim to work at ‘full capacity’ so that additional incentives are superfluous; the BMA refers here to intensity and innovation.

Many submissions lamented the decline in medical autonomy and de-professionalisation. The RCP refers to the impact that removal of the CEA scheme would have upon professionalism:

‘The professional status of doctors in regulating independently their own professional practice has been significantly eroded. The potential removal of CEAs to senior medical staff, thereby introducing a straightforward salaried service would exacerbate this trend’ (p.3).

Threats of removal of CEAs (due to individual poor performance) would be acceptable only if they were few in number since, it was argued, even a small number of withdrawals would ensure that the entire profession continued to meet the criteria of CEAs (similar to Le Grand’s earlier argument).

‘Awards only occasionally need to be withdrawn, indicating that the incentive of the award (and its potential withdrawal) is sufficient to encourage a sustained commitment to delivering the objectives of the scheme’ (BMA submission, para.1.17).

Several submissions referred to the socialisation within the medical profession. CEAs were, it was argued, part of the way in which a doctor learned to be an ‘excellent’ doctor. The Medical Schools Council argued that CEAs supported junior doctors in this academic specialty:

‘CEAs have been a useful counter-balance which provides the necessary incentive for younger clinical academics to sustain their academic pursuits in research and teaching despite the concomitant financial disadvantages’ (p.1).

Likewise, CEAs for clinical academics were a reward for educating the next generation of doctors.

‘They also have a vital function as role models for more junior colleagues and of encouraging them to play an active part in the professional responsibilities of teaching and education’ (BMA submission, para.1.78).

The effects of CEAs upon doctors’ morale and the negative effect that removal of award schemes would have were often noted.

‘Whilst one effect of an award is financial, it is also a source of pride to recipients and the factors of lay, employer, and peer assessment involved are significant and unique’ (RCP submission, p.2).

Arguments were often partial as they overlooked the morale effects upon staff who did not get an award or who were not eligible. The West Midlands Regional Committee of ACCEA noted that only doctors were eligible and justified this on the basis of their leadership of clinical teams:

‘It is appreciated that the bonus scheme does not extend to nurses, laboratory consultants etc. It is possible that the scheme should be extended to include others but that even though most consultants work in teams they are usually led by a consultant and that nurses and others play their part rather than leading these teams’ (p.3).

This 'morale' argument would seem to be less about the financial value of CEAs per se and more about a recognition of their social value.

Whilst some argued that fairness and equity has been achieved in the distribution of CEAs, following some criticism in medical journals about discrimination among women and minority ethnic doctors (e.g., Esmail *et al.*, 2003), the tone of the submissions was that CEAs were now distributed fairly. It is significant, therefore, to note that only a one-page submission was made from the Women's Medical Federation and no submissions were made from groups representing minority ethnic doctors. One submission (from the BSR) did advocate stronger patient and public involvement.

Doctors as knights and knaves: a re-assessment

In this paper, we examined the motivation of the medical profession with regard to CEAs. We used the lens of knights and knaves to interpret the profession's attitude towards financial awards.

Written submissions to the DDRB consultation illustrated the range of medical opinion, from major professional bodies (such as the RCP) and the doctors' union (BMA) to individual doctors. Such extensive and detailed data are usually unavailable elsewhere. However, in responding to the consultation, preferences and interests were revealed. Yet, the submissions were partial and sought to defend a position. As the quality of medicine has hitherto largely been defined, measured and rewarded by the profession itself, it is hard to judge (from these data) how far CEAs motivate members of the medical profession beyond what they would have done anyway. The longevity of the CEA scheme might also denote a further sense in which it has become socialised into medical politics and, with the majority of consultants getting an award; that is, an entitlement for senior doctors and an incentive to junior doctors.

The medical profession showed a remarkable degree of consistency in the content, tone and scope of its arguments. Such consistency might be evident of a logic which sought to forge a new professionalism, accommodating traditional forms of medical power with external imperatives. Submissions thus sought to secure cohesion of/within the profession in the face of further stratification. Such a strategy is significant since the authors of the submissions (from representative medical bodies) comprise the administrative elite (Freidson, 1994). Their views may not thus coincide with those of the rank-and-file. Submissions from individual doctors were analysed although it is hard to gauge whether this small number represented wider opinion amongst doctors. Equally, the individual submissions tended to reflect existing award holders rather than, say, those without CEAs or junior doctors. Their opinions would be worth investigating.

Whilst traits of both knightly and knavish behaviour were visibly apparent (*cf.* Disney *et al*, 2013), many of their arguments relied on an inter-dependence between them (Frey, 1997; Frey, 2013; Klein, 2012; Le Grand, 2003). Thus, extrinsic rewards were required, they argued, to secure their intrinsic motivation. However, whilst doctors displayed strong 'knightly' characteristics (of working 'over and above' contractual requirements, working beyond contracted hours, etc), they also argued that the CEAs were an essential part of the financial recompense that doctors deserved. Doctors' claims that removal of CEAs would threaten knightly behaviour thus appear a knavish strategy.

The 'crowding out' effect of intrinsic motivation of CEAs was not apparent in this evidence. As the profession has continued to control the criteria by which CEAs are allocated and the decision-making processes which distribute the awards, it could be argued that intrinsic motivation has been 'crowded-in' by the continued 'ownership' of CEAs (Frey and Jegen, 2001). Knaveish doctors would also still benefit since they may be more adept at completing CEA application forms and relying on clinical networks to influence local CEA committees. Clearly, some senior doctors may receive a CEA but may not be motivated further by it (Le Grand, 1997: 162; 2003: 105). These 'free riders' may be contrasted with those doctors who do not apply

(perhaps for moral reasons), whose applications are not successful but who still work 'over and above' contractual requirements (e.g., long hours) and who are subject to discrimination in their CEA application. Such views are moderated by the growing sense of entitlement to CEAs now that over 60 per cent of consultants get an award. Indeed, some submissions recognised that CEAs had become a de facto career ladder. Intrinsic and extrinsic motivation are thus intertwined.

As the profession has continued to 'own' CEAs, managerial reforms (e.g., 'organisational' criteria or managerial representation on CEA committees) have not significantly undermined medical power. So, rather than the medical profession being co-opted into state apparatus and its managerial discourses, the profession has been able to articulate a reconciliation between external challenges and medical professionalism. As a result, the profession can deflect and absorb such challenges through a subtle and on-going re-definition of what it means to be an 'excellent' doctor. This absorption has rested upon a judicious mix of managerial arguments (as shown by acceptance of PRP) and a new professionalism (which signifies the traits of what being an 'excellent' doctor is supposed to entail). This is redolent of 'soft bureaucracy' (Courpasson, 2000) whereby external 'control' (here, the prospect of CEA reform) needs to be vague enough to reflect local (here, professional) circumstances but sufficiently testing to prompt professions' reactions (in the accounts we examined).

The traditional norm of the medical profession has been avowedly knightly rather than knavish. Yet, the paradox that members who display such altruism might also be well rewarded financially requires explanation. So long as the administrative elite of the medical profession are able to defend the extrinsic benefit of CEAs on the grounds of altruism and self-interest, its (rank-and-file) members can legitimately claim to (only) be motivated by intrinsic factors (Klein, 2012).

Although the prospects for CEA reform now seem stronger than in recent years, it is not certain that wholesale change is imminent. Judging by the submissions to the DDRB consultation, CEAs

symbolise a strong characteristic of the medical profession's extrinsic motivation. Its ability to deflect and absorb external challenges through re-framing the criteria and through maintaining control of CEA allocation suggests that CEAs will remain a feature on the NHS landscape for the immediate future.

Conclusion

Le Grand's thesis of knight and knaves remains relevant in contemporary social policy debates. However, its elaboration and empirical applications in health-care organisations and/or in medical professional settings have been rare. This paper offers, therefore, a distinctive contribution to this debate. It combines a theoretical elaboration of his thesis in relation to an empirical application of CEAs awarded to English doctors. Interpreting the merits of intrinsic and extrinsic motivation is also salient given recent emphasis on performance-related pay in public service organisations. Both forms of motivation were apparent as well as their interdependence. However, this paper emphasised the views of the administrative elite of the profession; views from the rank-and-file of the profession were more limited and require further investigation.

The paper revealed the logic and discourse of the medical profession in justifying CEAs and resisting reforms to them. The consistency of these logics denoted the extent to which the medical profession had marshalled its interests and influenced local and national agendas. The profession's enduring and flexible power is revealed through its re-shaping notions of 'excellence' and its relative dominance of committees distributing CEAs.

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