Master Thesis

Accounting and Control

The physician perspective of patients' empowerment: A study of Zorgkaart Nederland

Radboud Universiteit

Abstract

This thesis explores what role Zorgkaart Nederland plays in the daily practices of Dutch hospitals. Zorgkaart Nederland is an online evaluation website where patients can share their experiences, write evaluations, and grade their healthcare providers, such as doctors and health insurers. This research contributes by providing new insights into the unexpected or unintended effects of Zorgkaart Nederland to daily practices of physicians. This exploratory case study was conducted with different physicians from two medium-sized regional Dutch hospitals. Results indicate that the most unexpected or unintended effects of Zorgkaart Nederland are publication bias, the reliability of a review, the accessibility of patients after a review, the vulnerability of physicians, the expectations of patients about a consult with physicians, and the increasing empowerment of patients. Except for the negative effects, some physicians also believe in concepts of Zorgkaart Nederland if patients write more reviews online to get a fair and reliable overview of the available and best fitting physicians.

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1 Introduction

New public management (NPM) is a set of assumptions and value statements for public sector organizations pertaining to how these organizations should be designed, organized, and managed as well as how they should function (Diefenbach, 2009). NPM creates the need for more accountability in public sector organizations. The goal of NPM is to increase the pressure on public sector organizations to perform well, resulting in more business-like and market-oriented public sector organizations (Diefenbach, 2009). NPM results in more effective and efficient organizations. To achieve these goals and to reflect on the performance of public sector organization, transparency is important. Thus, relevant, reliable, and timely information about the actions of public organizations should be available to the public (Kondo, 2002).

One way to achieve such transparency is with rankings. Rankings were created as a result of the need to 'update' public sector organizations into more business-like and market-oriented organizations (Diefenbach, 2009). With this increasing need for accountability, the need for performance measurement and rankings is also increasing. Performance measurement is increasing in popularity as a way to measure the condition of organizations. These performance measurements make ratings possible, which results in a ranking. Through rankings, performances can be evaluated and compared with those of other public sector organizations. Rankings thus are a way to evaluate organizations' performances, making them more accessible to outsiders. However, rankings can have also unintended consequences. They can, besides evaluating organizations, also change organizations (Sauder & Espeland, 2009). This is because of the reactivity of rankings: Organizations and people change their behaviour in reaction to being evaluated. This is also applicable for organizations because the people working there change in reaction to their organization being ranked. Sauder and Espeland (2009) analysed the change of organizations in different law universities in the United States. Sauder and Espeland (2009 concluded that the universities adjusted their performance according to how they were ranked. Sauder and Espeland (2009) further explored some unintended consequences of rankings on law universities in the United States. For example, rankings could change perceptions, expectations, decisions, and actions. This is because of the characteristics of surveillance and normalization, which are intertwined with the rankings of organizations. Surveillance results in disciplinary power and normalization is the usage of normative criteria to establish individual differences (Sauder and Espeland, 2009). In addition to Sauder and Espeland's identification of some negative aspects of ranking, Scott and Orlikowski (2012)

found that surveillance and scrutiny result in more focus on the results of the rankings than on the quality of the organizations.

Besides the education sector, rankings also affect the healthcare sector. For example, Wallenburg, Quartz, and Bal (2016) and Wallenburg and Bal (2018) analysed the rankings of healthcare organizations. Wallenburg and Bal (2018) explored how rankings and social media shape daily healthcare practices, by different reactions of ranking in healthcare practices as 'gamification'. Gamification refers to the play-like character of social interactions, supported by the datafication of care that formed the playing arena. They identified three different reactions – playing, ignoring, and changing the game. The focus of Wallenburg et al. (2016) is more on the governance side of rankings, such as investigating which consequences appear for the governance with public rankings. In both papers, rankings are included in the development of a tool to measure the work routines and relationships between different actors in society.

These rankings to measure different work routines and relationships between different actors in society also applies in health care. Zorgkaart Nederland is an online evaluation website where patients can share their experiences, write evaluations, and grade their healthcare providers, such as doctors and health insurers. With the information provided by Zorgkaart Nederland, people can find the best healthcare providers (Zorgkaart Nederland, 2019). The research of Wallenburg et al. (2016) about Zorgkaart Nederland investigates how hospitals and physicians respond to rankings and how ranking affects the governance consequences in hospitals. In this context, Kleefstra (2016) has already explored patients' experiences with health care providers. However, because physicians' perspective is also important to explore, this research adopted that focus.

This research explores the daily practices of healthcare performance by adopting a practice theory lens (Nicolini, 2012). In this theory, practices are viewed as the basic units for understanding organizational phenomena (Nicolini, 2012). Rather than just describing the daily practices of doctors, practice theory sees the activities, performance, and work of doctors as crucial factors in social life (Nicolini, 2012). Practices are meaning-making, identity-forming, and order-producing activities (Nicolini, 2009). In this research, rankings were analysed with practice theory from the standpoint of a non-human actor.

This research expands on the research of Wallenburg et al. (2016) by exploring how hospitals and doctors respond to rankings based on their daily practices as well as on the gamification approach of Wallenburg and Bal (2018). In contrast to Wallenburg et al. (2016), this research is not based on actor-network theory but rather on the practice theory of Nicolini

(2012). The daily practices of physicians and their reactions to the ranking site Zorgkaart Nederland are explored and compared with the three gamification reactions proposed by Wallenburg and Bal (2018). This research focus resulted in the following research question: *How does Zorgkaart Nederland shape daily practices of physicians in Dutch hospitals?*

That question is analysed with a qualitative research method, in which an exploratory case study was used to give more practical examples and relevance to this research. An exploratory case study is the precursor to a large-scale research project (Zainal, 2007). A case study collects empirical evidence from one or more organizations in order to study a subject matter in context. For this research, interviews were conducted with nine physicians and the patient complaint departments at two medium-sized regional Dutch hospitals as well as with a product manager and a staff member at Zorgkaart Nederland. Together with these interviews, relevant documents were analysed in order to answer the research question.

This research about how Zorgkaart Nederland shapes daily care practices is relevant for the academic literature and for society. The academic and scientific relevance of this research is that it provides knowledge about the unintended consequences of rankings on the daily practices of physicians in Dutch hospitals. For example, rankings shape care practices by changing what physicians do and say. Regarding the practical relevance for society, this research gives insight into how Zorgkaart Nederland plays a role in the daily practices of physicians and how it has possible unintended consequences. Thus, one result of this research is that physicians are not very interested in the system of Zorgkaart Nederland. Zorgkaart Nederland, part of the Dutch patient federation, recognizes the importance of giving patients a voice. Moreover, in this research, by taking the physicians' perspective into account, this research can improve Zorgkaart Nederland.

The thesis continues as follows. Chapter 2 provides the theoretical framework, which is mainly focused on the practice theory of Nicolini (2012) and the gaming theory of Wallenburg and Bal (2018). Chapter 3, the methodology, describes the exploratory case study and how the interviews were conducted. Chapter 4 discusses the most important results of the interviews. Chapter 5, the discussion, provides a reflection on the results. The conclusion answers the research question.

2 Theoretical framework

2.1 Performance measurement in health care

In order to understand how Zorgkaart Nederland shapes physicians' daily practices, it is important to understand how performance is measured in a public organization as healthcare. Public sector organizations (PSOs) are entities that have been formed to manage the policies and requirements that enable a government to achieve its goals (Callender, 2001), and one way PSOs achieve those goals is through NPM. According to Andrews and Van de Walle (2013) and Hood (1995), the basic purpose of NPM is to clarify the differences between the public and private sectors. It is a way of reorganizing PSOs in order to bring their management, reporting, and accounting approaches closer in line with accepted business methods (Dunleavy & Hood, 1994); thus, NPM is about what should be done or how it should be done to solve public problems. Hood (1995) described this as steering (giving PSOs the right direction) instead of rowing (letting PSOs create their own direction). According to Diefenbach (2009), NPM seeks to transform PSOs into more business-like and more market-oriented organizations. Bryson, Crosby, and Bloomberg (2014) also explored the transition from traditional public administration to NPM. In NPM, efficiency, effectiveness, and democratic values are important factors. Moreover, the emphasis shifts from process accounting to accounting with an emphasis on results. These accounting results could put more pressure on the performance of public sector organizations.

Public sector organizations can use performance measurement to learn and to improve performance. This is also known as the learning purpose of performance management (Verbeeten, 2008). Performance management practices include the goals of achieving, selecting strategies to achieve these goals, allocating decision rights, and measuring and evaluating performance (Verbeeten, 2008). Because healthcare organizations, especially hospitals, are considered PSOs, performance measurement systems have grown in importance in the healthcare sector, pressuring hospitals to manage and improve their effectiveness and efficiency (de Harlez & Malagueño, 2016). Moreover, NPM has also played a significant role in the importance of performance measurement in health care. The emergence of performance measurement has increased the pressure on hospitals (Van der Geer, van Tuijl, & Rutte, 2009). As a result, hospitals are increasingly asked to provide clarity and to account for their performance (Wallenburg, Quartz, & Bal, 2016). In hospitals, performance measurement can be used to evaluate hospital quality with regard to certain processes of patient care, such as mortality rates or complication rates (Werner, 2006).

Transparency in hospital performance is also increasing in importance. Transparency means that the relevant, reliable, and timely information about the actions of public organizations are available to the public (Kondo, 2002). Information about such performance enables consumers to make choices and to contribute to the competition between health service providers (van de Bovenkamp, 2016; Wallenburg, Quartz, & Bal, 2016). In order to shed light on important things that otherwise would be invisible, consumers seek guidance from others (Roberts, 2009). Indeed, transparency makes performance visible and comparable. This can be done through rankings that show a hierarchical ordering of performance and effectiveness (Eaton, 2013).

2.2 Rankings

The popularity of rankings has increased exponentially in the last decades (Sauder & Espeland, 2006; Sauder & Lancaster, 2006). Rankings and other similar report cards have become a common way for organizations to combine and present information about a list of options for consumers (Pope, 2009). Rankings standardize, simplify, and quantify performance information, and they display clinical work as accessible and manageable (Wallenburg, Quartz, & Bal, 2016).

Rankings consist of descriptive evaluations and grades, and they can result in new interpretations of situations. In this regard, rankings can be viewed as engines because they are an important mechanism for organizations (Espeland & Sauder, 2007). Rankings as an engine produce and reproduce a hierarchy of organizations because rankings encourage small differences among similar organizations, which can transform in larger differences over time (Espeland & Sauder, 2007). Although rankings have an appeal to outsiders, rankings still lack easy management, and powerful insiders do not like the idea of rankings. These critics turn into rankings that decide how resources are allocated, decisions are made, and the status of an organization is defined (Espeland & Sauder, 2009). Because of the scrutiny of rankings, former irrelevant information becomes relevant. Rankings force people to analyse details that were previously ignored. Thus, rankings have become naturalized and internalized as a standard of comparison and success (Espeland & Sauder, 2009).

According to Pope (2009), academic research has shown that rankings can have an impact on consumers' decision making. As a result, organizations like hospitals take rankings seriously. Most organisations' evaluations are written online by consumers. Scott and Orlikowski (2012) researched how expanding online technologies have enabled online ratings

and rankings. This trend has resulted in a reorganization of accountability; information goes in different directions, moving boundaries and changing relationships. An example of such moving boundaries is the shift from offline evaluations to online valuations (Orlikowski & Scott, 2014). This shift changes how consumers write evaluations, and multiple evaluations must be given for an organization to receive a certain ranking.

Rankings are popular because they are a form of remote surveillance and because they give outsiders access to the inside nature of an organization (Shore & Wright, 2015). Rankings help create an environment in which it is easier to review evidence of real qualitative improvements in ranked areas. They can also be used to evaluate organizations or competitors (Downing, 2013). Performance can also be evaluated with rankings by means of the performance measurement being visualized. As a result of these performance measurements, a ranking of different PSOs arises. Such rankings influence organizations and institutions. They shape strategies, structures, and practices (Shore & Wright, 2015). Previously, this performance measurement of quality control was only done internally or was contracted externally (Adams, 2011). Rankings are thus developed as a growing importance in organizations.

Due to such growing popularity, ranking itself is developing into an industry and is being used by an increasing number of public organizations, like hospitals (Wallenburg, Quartz, & Bal, 2016). For example, in the healthcare sector, patients publicize their personal experiences with healthcare providers. The physicians in a hospital can then use these experiences to improve their skills. The shared information is also available for other patients, hospitals, insurance companies, and healthcare professionals. Wallenburg et al. (2016) concluded that this shared information about hospital rankings result in much quantifying work in valuating organizational and medical work. In the end, these valuations are put into numbers. Besides such quantitative valuations, hospitals hire and set up employees or committees to manage the data of their rankings. According to Wallenburg et al. (2016), hospitals are becoming more open to renegotiations regarding practices and power relationships. In this regard, performance measurements in the form of rankings evoke practices in which good evaluations are rewarded and poor evaluations are ignored (Wallenburg & Bal, 2018). This reactivity can affect patients, hospital managers, and physicians. When hospitals are rated low, performances are improved.

2.3 Responding to rankings

Rankings are a social phenomenon, and people respond to rankings (Pollock & D'Adderio, 2012). When an organization is evaluated, people react. For example, the evaluated people want

to motivate or defend themselves based on the rankings. Espeland and Sauder (2007) named this responding 'reactivity', which is how people change their behaviour if they know they are being observed, evaluated, or measured. According to Espeland and Sauder (2007), rankings result in reactivity because they change how people think and react to situations – for example, with self-fulfilling prophecy or commensuration. Self-fulfilling prophecy are processes by which reactions to social measures confirm the expectations or predictions that are included in measures. Self-fulfilling prophecy encourages people to adapt their behaviour towards the calculation. Commensuration, on the other hand, changes the form and circulation of information and how people attend to this information. The impact of rankings on an organization, for example, can be direct (Espeland & Sauder, 2007).

Sauder and Espeland (2009) also researched how people react to ranking. The authors found that rankings, as the public's measurement of performance, are increasingly more important in (institutional) environments. In addition, the reaction of organizations is also important. Rankings change the behaviour and decision-making of people. Organizations adapt in line with evaluations and create guidelines for decision-making in order to survive and achieve success (Espeland & Sauder, 2007). Thus, rankings and the reactivity cause help organizations to know if their rank positions are being maintained or if they must be improved.

2.4 Gamification

The reactions to rankings can be various. Reactivity refers to how people react to different actions. In this regard, Wallenburg and Bal (2018) analysed the effects of quantified performance data and social media on healthcare practices. Wallenburg and Bal (2018) used gamification to explore different reactions to the ranking of healthcare practices. Gamification is the integration of game terms in an environment to give that environment a game-like feeling (Sardi, Idri, & Fernández-Alemán, 2017). Gamification refers to the play-like character of social interactions, supported by datafication of care that formed the playing arena. With datafication, many social aspects are turned into data. Gamification sets frames for playing and for earning rewards. Wallenburg and Bal (2018) found three different reactions – playing, ignoring, and changing – that describe the daily practices in a hospital.

In the first reaction, 'playing the game', data collection is seen as a kind of competition that can be won and that provides joy to those who do well. Achievements can be celebrated and awarded, and poor performance can be punished. To achieve good performance, data can be taken over and used in new ways, which could lead to misconceptions (Wallenburg & Bal,

2018). Performance valuation is adapted in most organizations, also in the healthcare sector. In hospitals, an example of playing the game is considering the performance indicators of a ranking in a small competition between different physicians by measuring the daily activities of physicians.

In the second kind of reaction, 'ignoring the game', physicians do not take the performance indicators into consideration to set the ranking; instead, they only comply with them by maintaining their own quality norms. This response is characterized by physicians preventing all kinds of performance valuations. Refusing to participate in a certain 'game' in healthcare is part of someone's attitude regarding professional, organizational, and patient values and goals (Wallenburg & Bal, 2018). By ignoring some measurements, people can focus on other important measurements in a hospital.

In the last reaction, 'changing the game', data collection enables the development of new strategies to improve the health care sector. Changing practices can be viewed as changing the rules of the game – for example, by adjusting the setting in new practices of care (Wallenburg & Bal, 2018). In this research, physicians could embrace performance valuations to a certain extent and improve their work and the quality of their work. Change requires creativity and results in the innovation of health care. The definition of good care and good professionalism can be shaped and reshaped by practices – not just by playing the game but also by adopting new, creative ways of thinking.

In this research into Zorgkaart Nederland, these terms of gamification will also be explored. In order to explore how rankings shape daily practices at a local hospital, a practice lens is also adopted, as discussed in the next section.

2.5 Practice theory

With regard to practice theory, different authors have made important contributions. For example, Reckwitz (2002) has conducted much research into the meaning of practices. Feldman and Orlikowski (2011) developed the practice lens, which consists of three focuses pertaining to daily practices: the empirical focus, the theoretical focus, and the philosophical focus. Last, Nicolini (2012) described four important differences between practical techniques and theoretical techniques in social life.

According to Reckwitz (2002), a practice is something social. It is a way of behaving and understanding things at different times and in different places. Practices can also be continuous behaviours, whereby the elements are interconnected with each other (Reckwitz, 2002). All everyday activities and daily practices are important for social life. According to Dixit (2002), in the public sector, the outcomes of one practice affect different people or groups. The relation between practices and their conditions (structure and process) is seen as a two-way interaction; it continuously repeats. In practice theory, individuals are not the subject of the analysis but rather are viewed as carriers of the practice (Reckwitz, 2002). Social interaction is therefore important in practice theory.

2.5.1 Practice lens

Central to practice theory is the practice lens (Feldman & Orlikowski, 2011), which contains three parts: the empirical focus, the theoretical focus, and the philosophical focus. The empirical focus (i.e. the 'what') is about the actions of people in organizations; it is about the doings of practitioners. The empirical approach also reflects the increasing importance of practices in the daily practices of organizations. Next, the theoretical focus (i.e. the 'how') is about the relation between the actions of people and the structure of an organization. It is about daily activities and specific explanations of an activity; thus, this focus is more about the words of the practitioners. In the last focus, the philosophical focus (i.e. the 'why'), the daily activities are viewed as the primary building blocks of the social reality. In this sense, the social world consists of practices. Of those three focuses, practice theory is synonymous with the theoretical focus (Feldman and Orlikowski, 2011) in which, everyday actions are responsible for the social life.

This research explores if the practice lens of Feldman and Orlikowski (2011) can be adjusted to the daily practices of physicians. The practice lens is thus explored, together with the four important parts of practices in a society of Nicolini (2012). These four parts are discussed later in this section.

The main goal of a practice approach is to uncover someone's work and effort that is hidden behind all the durable features of work jobs in the world (Nicolini, 2012). Practices are the basic units for understanding organizational phenomena. According to Ortner (2006), practice theory seeks to explain the relationship between human actions and systems. According to Nicolini (2012), practice theories are commonly relational and see the world as an assemblage, collection, or independent cooperation of practices, with or without the same relevance. The practice approach has become increasingly popular in organizations. Viewing concepts as practices, interactions, activities, performativity, and performances are growing in importance (Nicolini, 2012).

Practice techniques in social life are different from theoretical techniques in a few ways. First, the way activity, performance, and work affect the creation and maintenance of all aspects of social life is important for the practice theory. Practices are an ongoing and routinized process. Practice theories are relational and see the world as an assemblage (an ongoing process) of practices (Nicolini, 2012). These practices do not need the same relevance.

Another important aspect of practice theory is the critical role of the body and of material things in all social affairs. Most practice theories see practices as routine activities made possible by a few material resources (Nicolini, 2012). Therefore, a practice is viewed as the routinized activity of the body. Objects thus connect different practices and participate in accomplishing the practices. Objects participate in the performance of the practice and make this performance durable over time. Nicolini (2012) gives an example of a classroom: A class can be called a class with the right participants (students) and with the practices (activities of the teacher) and objects (such as desks). In this research, practice theory (Nicolini, 2012) can be used to analyse the daily practices in a hospital as Nicolini did in a classroom. In a hospital, the three important parts also exist: the right participants (physicians), practices (treatments), and objects (healthcare instruments). These three concepts are needed to define the work in a hospital.

Moreover, practice theories clarify a specific space for individual agents who are commonly known as the *homo economicus*, a rational decision-maker. Similarly, in practice theory, the *homo practicus* refers to viewing a person as a carrier of practices – that is, as a body or mind that carries and carries out social practices (Reckwitz, 2002). A physician can thus be viewed as a body or mind that carries out (social) practices. Without physicians, illness cannot be treated. To treat patients, the practices of physicians are needed. In this regard, the focus is not on the action of the individual, but on the practice of the individual. Practices of physicians are never completely the same because they must adapt to new circumstances.

With practice theory, there is also a different view of knowledge – namely, as a social and material activity. Knowledge is collected and shared with others, and practical methods are learned through others. These two aspects come together in different activities. When something is part of a practice, someone must learn how to act, how to speak, how to feel, what to expect, and what things mean (Nicolini, 2012). All physicians have learned their practices from other physicians. New theories or instruments are developed with the expertise of other physicians or professionals in that area.

Finally, according to Nicolini (2012), practices put people and things in place, and they give or deny people the power to do things and to think of themselves in certain ways. This results in competitive practices, keeping the practices up to date when more improved, newer practices emerge. Physicians teach others and themselves by doing the daily practices. However, there is also research regarding how new and improved practices or instruments improve the daily practices of physicians. Practice theory puts knowledge in a new light. Human and non-human actors are part of people's actions. In a social network, people take many actions. These actions are the basis of practice theory, which forces organizations to rethink the role of agents and individuals in their structure (Nicolini, 2012).

Practice theory demonstrates that the daily practices of physicians are important. With the practice theory, these daily practices can be understood in the meaning of the activities of a physician, the action they take for these practices and the actions the physician takes to do their jobs. In sector 4.2, the main practices of a physician will be discussed. The individual actions of physicians are important in a social world. According to Nicolini (2012), social practices must be understood as a material reality. In this research, the daily practices are the subject of the investigation into Zorgkaart Nederland. Physicians are evaluated based on their daily activities, actions, and work practices. These practices are thus the practice lens, which is what matters in social life.

3 Methodology

3.1 Qualitative interpretive research

This thesis uses qualitative interpretive research to explore the role of Zorgkaart in the daily activities of healthcare providers. Interpretive research consists of three parts (Chua, 1986): The first part considers beliefs about reality – namely, how reality is produced. In interpretive research, reality is produced through a process of continuous social interactions. With such interactions, meaning and norms become objectively real, and reality changes continuously. According to Parker (2012), in qualitative research, reality is created by the interaction of different actors with each other and with their environment. Qualitative research emphasizes the understanding and critique of such processes and of the environmental context as well as the recognition of the uniqueness and differences of various actors (Parker, 2012).

The second element of this interpretive research consists of questions about knowledge – namely, how knowledge is produced, what the role of theory is, which methodologies are relevant, and what the role of the researcher is. In interpretive research, knowledge is produced by studying, observing, and understanding daily practices. Theory is both an input (i.e. an informer) and an output (i.e. a deliverable) (Chua & Mahama, 2012). With qualitative research, new theories can be developed (Richardson, 2012). Qualitative research, according to Richardson (2012) has the ability to communicate certain insights and patterns pertaining to practice because such research is more accessible. With practice theory, the hidden work and effort of a physician can be uncovered. As a result, people can understand an organization better (Nicolini, 2012).

Interpretive research is also about the relation between theory and practice. Such research is directly involved in problems pertaining to daily practices and how practices may be influenced by the views of other practitioners (Chua, 1986). Knowledge is collected from the meaning of daily practices and not from the daily practices themselves. In this regard, interpretation is the most important way to create knowledge (Richardson, 2012). Knowledge can be created with practice theory because everything is part of a practice, such as how to speak, how to feel, what to expect, and what things mean (Nicolini, 2012). By sharing these aspects of practices, knowledge can be created.

According to Ahrens and Chapman (2006), qualitative research is both empirical and theoretical. It is important to express the research field but also to describe the research field and to clarify it for the reader. By adopting a practice lens, these patterns and insights can be explored. Practices are the basic units for understanding organizational phenomena (Nicolini,

2012). Thus, using practice theory makes it possible to explore the work of hidden effort. In this research, considering the daily practices of physicians are important for answering the research question: How does Zorgkaart Nederland shape the daily practices of physicians in Dutch hospitals?

3.2 Exploratory case study

This research into Dutch hospitals was based on an exploratory case study in order to develop a more complete and reliable view. A case study aims to understand social phenomena in natural settings (Bloor & Wood, 2006), and it collects empirical evidence from one or more organizations in order to study a subject matter in context. An exploratory case study is the precursor of a large-scale research project (Zainal, 2007).

The cases used for this study were selected by looking for two similarly sized hospitals with the same competitive background. Both hospitals, X and Y, are medium-sized regional hospitals and are not leading clinical hospitals. The patients of these hospitals are primarily local, or they come because of the positive experiences of their family members who live near the hospitals. Hospital Y participated with a pilot of Zorgkaart Nederland, and hospital X did not. The pilot of Zorgkaart Nederland consists of a plan to verify the patients who write a review on Zorgkaart Nederland by sending real patients of that hospital a link. In this way, the patient writes a review as a verified patient.

3.3 Data collection

In order to conduct this research, physicians and complaint departments from hospital X and hospital Y were explored by means of interviews and documentation. Two different methods were used to collect data: interviews and documents. Using different methods of data collection may shed light on different aspects of the question being researched (Bloor & Wood, 2006).

The first way data was collected was with interviews. Interviewing is one of the most common and powerful ways to understand human beings (Fontana & Frey, 2000). In this research, the most effective interview method was the semi-structured interview method, in which the structure of the interviews is planned beforehand. This consists of a few questions and topics deemed necessary to collect the most important data. At the time of the interview, then, interviewees are free of other questions, thus leaving them room to share other important information. The semi-structured interview method leaves room for interpretation, adjustments, and responses that are more detailed. In this way, information can be explored that otherwise

would not have been collected in a more strictly structured interview (Gill, Stewart, Treasure, & Chadwick, 2008).

Interviews were conducted with the physicians of hospital X and hospital Y as well as with the consumer complaint departments of both hospitals. Zorgkaart Nederland was also interested to get involved in this research. The author has spoken to the product manager and a staff member of Zorgkaart Nederland. The physicians interviewed had different specializations and were from different departments in order to obtain unique insights.

In total, 11 hospital employees were interviewed. Nine of them are medical specialists and the other two work in the complaints departments. Each interview lasted about forty-five minutes and consisted of around 20 questions (Appendix E) about the responsibilities of the employees, their daily practices before Zorgkaart Nederland, and their daily practices after Zorgkaart Nederland was launched. The questions were semi-structured to allow other important questions to be asked while talking about Zorgkaart Nederland. Prior to the conducting interviews, different relatives controlled the list with questions for the interview, and with their feedback, the questions are adjusted.

During the interview, notes were taken regarding topics to inquire about later in the interview. Further research was also done after the interview – for example, regarding abbreviations or medical terms that were mentioned. After each interview was completed, it was literally transcribed by using recordings (which the interviewees had approved). After these transcriptions, the text was coded on the basis of certain themes. The interviewees are anonymous, except for their job title and experience. The anonymity result in free conversation with the interviewees and with the hospital. When there are more interviews with employers with the same functions, these employers' quotes will be distinguished as for example physician A or physician B.

Table 1: Interview information

Interview	Date	Function	Experience	Duration
1	08-05-2019	Pulmonologist A (X)	24 years	29:54
2	08-05-2019	Pulmonologist B (X)	24 years	36:30
3	08-05-2019	Pulmonologist C (X)	4 years	32:01
4	13-05-2019	Pulmonologist D (X)	20 years	31:03
5	13-5-2019	Staff of Patient Complaint Centre (X)	1 year	17.47
6	14-05-2019	Internist (Y)	15 years	35:17
7	14-05-2019	Paediatrician (Y)	10 years	31:21
8	16-05-2019	Pulmonologist E (X)	30 years	54:34
9	16-05-2019	Cardiologist (Y)	10 years	42:03
10	16-05-2019	Staff of Patient Complaint Centre (Y)	5 years	16.51
11	20-5-2019	Gynaecologist (Y)	15 years	35:37
12	03-06-2019	Project manager Zorgkaart Nederland	11 years	1:16:04

The second method by which data was collected was through documentation, such as letters, reports, web pages, and newspaper articles. A document has a written text (Bloor & Wood, 2006). In this research of Zorgkaart Nederland, the author analysed one example of performance measurement of one department in hospital X (Appendix A). Hospital Y shared some other important documentation about the valuations of different departments in the hospital (Appendix B, C, and D).

3.4 Data Analysis

The inductive approach, whereby codes are derived from the data, was used to analyse the qualitative data from the interviews. The responses of the participants were divided into categories and labelled with codes. In the inverse approach, deductive coding, researchers set up a coding scheme on beforehand (Thomas, 2006). The interviews were then further analysed in light of the theory of Miles and Huberman (1994), according to which qualitative data analysis consists of three phases: data reduction, data display, and conclusion drawing. In this thesis, the data display will be excused. Data reduction is the process whereby the mass of qualitative data obtained is reduced and organized by coding. Coding refers to labelling units

of texts to capture the meaning of the text. Coding is important for enhancing reliability and rigour (Lee & Lings, 2008). Coding is the organization of data into conceptual categories (Miles & Huberman, 1994). Each category consists of different codes. Codes are labels for allocating units of information that are important for a given study. Codes can consist of different sizes: words, phrases, sentences, or whole paragraphs.

There are different stages of data coding. Open coding is the first stage, in which all important statements relating to the research question are identified and in which each statement is allocated a code (Miles & Huberman, 1994). In the next stage, axial coding, the qualitative data is read again, and the codes are divided into one of the categories. After these two stages of coding, the researcher looks for patterns in the different codes and categories. In the end, the researcher looks for explanatory, contradictory, or confirmatory statements. This last stage is known as selective coding (Miles & Huberman, 1994).

After this process, the codes and categories from the different interviews can be compared and contrasted. Atlas.ti provides an overview of the coded text parts. With the collected results, the main research question can be answered. The interview questions and the introduction document are attached in Appendix B. Possible answers in the next section are supported with quotes from the interviews.

4 Results

This chapter consists of the results of the research. In section 4.1, Zorgkaart Nederland is explained. In section 4.2, four different practices of physicians are discussed. In section 4.3, changes as a result of Zorgkaart Nederland are discussed. Finally, the role of Zorgkaart Nederland in these hospitals is explained in section 4.4. These sections contribute to answering the research question.

4.1 Ranking in the Dutch Healthcare sector: An introduction

The rise of social media has empowered, engaged, and educated consumers and providers in healthcare. Consumers not only can search and read information online (web 1.0) but also can create content online (i.e. web 2.0) (Sarasohn-Kahn, 2008). People tend to trust people who are like them more than authority figures from business, government, and the media.

Zorgkaart Nederland is an online evaluation website where patients can share their experiences, write evaluations, and grade their healthcare providers, such as doctors and health insurers. With the information provided by Zorgkaart Nederland, people can find the best healthcare providers (Zorgkaart Nederland, 2019). Zorgkaart Nederland makes it possible for patients to search for the best physician in a specialty that fits with their complaints. Thus, patients are not only looking for a hospital in specific neighbourhoods but also look for the best physician for their illness.

"Zorgkaart Nederland stands for searching, finding, and evaluating. People can see that also at our number of visitors, around one million people visit our website, but we are receiving only 10 to 12 thousand reviews. Most visitors are thus only searching and finding the information they need." (Staff member of Zorgkaart Nederland)

Patients are increasingly motivated to publicize their personal experiences with health care services by reviewing hospitals and professionals on the internet (Adams, 2011). Zorgkaart Nederland is owned by the Federation of Patient and Consumer Organizations (Nederlandse Patientenfederatie). On this rating site, patients can anonymously share their experience with health care professionals and leave a rating from one to 10. This rating is based on six factors: appointments, accommodation, employees, listening, information, and treatment (Zorgkaart Nederland, 2019). With a special subscription, hospitals or other healthcare providers have the ability to react to the reviews of patients.

A valuation website as Zorgkaart Nederland is not only about the satisfaction of patients but also about their experiences. According to Pflueger (2016), experiences are objective and verifiable expressions of the patient's inner world. A valuation makes it possible to separate the consumer from the provider, supporting the patient as both the subject and object of accountability. The actors in such surveys have the ability to problematize, manage, improve, know, account, compare, calculate, and hold accountable. A patient can thus be seen as a knowing subject and as a knowing object. A knowing subject, because patients are the main topic of Zorgkaart Nederland. The organisation wants the best for patients. Patients can also be a knowing object because physicians are treating the patients. With these objects and subjects, performances in daily practices can be measured. Not only are performance measurement systems like Zorgkaart Nederland widely used in practice, but they are also becoming important to the management of a hospital (Li & Benton, 1996). In appendices A to D, some examples of performance measurements in the explored hospitals are included.

Zorgkaart Nederland had made a number of improvements over the years. Patients must now clarify their ratings, and health care professionals have the ability to react to a review from one of their patients. To prevent unfair reviews, Zorgkaart Nederland checks every review with a code of conduct, and it compares the IP (internet protocol) address for every review to prevent one patient from adding multiple ratings in a short amount of time.

"A small part of the valuation approved automatically. These automatic approvals are increasing in amount because Zorgkaart is growing in importance and in the amount of posted reviews." (Staff member of Zorgkaart Nederland)

In addition to these automatic approvals, Zorgkaart Nederland has a special department of editors who control all the reviews in light of the code of conduct. When a review is denied, the reviewer can adjust the review until it is in line with the code of conduct. For this reason, Zorgkaart Nederland presents itself as a reliable and independent website – that is, reviews are only seen as reliable when a health care professional has nine or more reviews. For hospitals and nursing homes, the minimum is 30 reviews (Zorgkaart Nederland, 2019). Moreover, after a period of four years, old reviews are not used in the total evaluation of the physician.

"Based on scientific research by the University of Amsterdam, an online evaluation is reliable if a physician has a minimum of nine reviews and if a healthcare provider has a minimum of thirty reviews." (Staff member of Zorgkaart Nederland)

4.2 The daily practices of physicians

The daily practices of physicians in a hospital differ according to health care specialization, department, and hospital. In this research, physicians with different specializations were interviewed at two different hospitals. As a result of the coding of the interviews, four main practices were obtained, which will follow in the next four subsections. These four main practices of physicians rotate weekly.

4.2.1. Outpatient clinic care

One of the main practices of a physician in a hospital is the outpatient clinic care. The hours of an outpatient clinic are comparable with the consultation office hours of a general practitioner. These consults in an outpatient clinic care of physicians are prepared in advance. The medical history or outcomes of a physical examination are analysed beforehand. Before patients see the physician, a minor examination is done by the nurses. Physicians see, on average, returning patients for 10 minutes and new patients for 20 minutes. The duration of a consult with a new patient differs in each department of a hospital. In a consult, physicians listen to the complaints of the patient and diagnoses the patient with the right treatment plan. Patients of outpatient clinics can be recommended by the general practitioner or by the first-aid department of the hospital.

4.2.2. Treatment room

The second main practice of a physician in a hospital is the treatment room. In the treatment room, physicians can do some human intervention with patients, which could consist of physical examination or other research. The patient can then be recommended for outpatient clinic care or the first-aid department of a hospital. In the treatment, physicians do necessary or recommended operations. The difference between a small physical examination before or during a consult and the environment in the treatment room is that some incisions could be involved, thus requiring a sterile environment. As a result, patients and/or relatives are prepared in advance.

Except for operations, physicians also visit patients who are hospitalized in order to talk with the patients and with their relatives. Physicians treat the patient until they are well enough to be discharged from the hospital.

4.2.3. Emergency service

The next main practice is the emergency service. Emergency service requires physicians to be available for any emergency patient for a few days or a whole week, including the weekend. Depending on the hospital, physicians need to be available on an on-call basis, or they need to be continuously available in the hospital. Emergency service is administered to clinical patients in a hospital or to patients forwarded by a general practitioner. The practices of the emergency service include first aid and intense care. Because of the sometimes-chaotic environment in a hospital, there are strict rules for physicians. When physicians have emergency service, they cannot be called for the outpatient clinic so that a physician is always available in case of emergency and so that other practices cannot be interrupted by an emergency visit.

4.2.4. Telephonic consults and e-consults

Contact with patients outside of consults in the hospital differs in each department and hospital. Such contact may include contact by phone or by email (i.e. an e-consult). These other ways of consulting have been developed to prevent crowded waiting rooms. Depending on the physician, contact by phone is used differently:

"I only use contact by phone instead of face-to-face contact when the duration of the telephone conversation is less than a minute." (Physician X3)

"When you see patients in real life, the conversation will be different compared to a telephone conversation." (Physician X4)

"All patients who are admitted in our hospital ward receive a phone call from a nurse of our department within five days after dischargement. In this phone call, the nurse asks the patient if the patient understood all agreements and if the patient understood all explanations. Except for these questions, the nurse asks the patient about their opinion of their stay in the hospital." (Physician Y9)

Physicians use telephonic consults for simple messages to the patient, such as to communicate that a patient is allergic to something or after a patient has started a new medicine. Other physicians sometimes share good news to a patient by phone before the patient comes to the hospital for a consult. In the case of a bad outcome, the physician can call the patient for an appointment. Hospital X also has a special list for emergency patients who have always the

option to call a physician. In this way, physicians are always concerned with the health of their patients. In some departments, physicians outsource the telephone calls and e-consults to assistants who share the outcomes of those communications with the physicians.

Contact by phone is more in use than contact by email because email must be secured by a special program. Mail contact is also known by e-consulting, in which physicians answer questions with a secured mailing program. One of these consults is only seen as a real consult if it includes listening to the complaints of the patient and amnesia of the complaints and if in the end, a treatment plan is compiled for the coming period. The danger of such consulting is that physicians can be misused by patients; patients can ask physicians anything in this way. The physicians who were interviewed reported that they were afraid of their jobs becoming computer based. For example, physician Y8 said:

"The danger of these upcoming ways of patient-doctor contact is that our job will transform is a more computer-based job instead of the human-based job which is the reason for most doctors to choose this direction".

Above mentioned practices are the basic units to run a hospital. According to the interviewed physicians, the most important objects in a daily practice of a physician are the patient, the instruments to treat a patient and other smaller instruments or devices that are also needed to accomplish a good consult with a patient. The consult can be in an outpatient clinic care, in a treatment room, in the emergency service or with a telephonic- or e-consult. The objects connect different practices and participate to accomplish the daily practices of the physician. The connection of different practices also connects different physicians that can share their knowledge with others. This shared knowledge can also lead to new innovative knowledge. The public reviews of Zorgkaart Nederland result in some competitive practices between physicians to give patients the best care they need.

4.3 Changes by Zorgkaart Nederland

Resulting from the conducted interviews in this research is the role of Zorgkaart Nederland in Dutch hospitals small. In this section, a few aspects that were changed by reviews on Zorgkaart Nederland are explained.

Most of the interviewed physicians mentioned that they were willing to change their practices and behaviour to treat patients if enough patients assessed them negatively on a specific aspect of their practice. For example, one physician said he would change that specific aspect. Another physician said he would be willing to change if a patient was serious about a complaint and if it was true according to other co-workers. In this way, physicians could improve their practices with the reviews of patients. When complaints pertain to an organizational issue, in addition to the physician having to change, the whole department or hospital needs to do so as well. However, physicians do not often have to deal with unsatisfied patients. All people, including physicians and patients, want to be liked. It is not good that the relationship between patients and physicians can change with external factors. Patients may think that if they are nice to physicians, the patients will get a better treatment – for example, by giving gifts or by asking questions about good news in their families. It depends on each physician whether they can be influenced by such gifts or compliments. The practices of physicians could be changed, for example the duration of a consult or extra telephonic contact after the consult. Patients may also give gifts because they are thankful for the service of the physician.

Although each interviewed physician was familiar with Zorgkaart Nederland, they did not all use it. In fact, none of the interviewed participants checked their Zorgkaart regularly – they only did so once in a specific time period. Hospitals have special services that communicate with health care providers in the hospital when they have a new review on Zorgkaart Nederland. Most of the interviewed physicians thought that not all patients knew about the existence of Zorgkaart Nederland.

After receiving bad reviews, some physicians said they decided to never look at these websites again and to not do anything about the bad reviews in the future. Others participated in a talking group with other physicians who had received bad reviews in order to learn how to deal with negative feedback. In this way, physicians do not adapt their daily practices. The evaluation of patients is a one-way evaluation. Physicians are not involved in the process of writing a review. Other physicians temporarily quit their jobs. Nevertheless, the interviewed

physicians also reported receiving many positive reviews. Despite this, the physicians were not very interested in Zorgkaart Nederland.

Besides the relationship between physicians and Zorgkaart Nederland, some practices change or appear because of the emergence of online reviews. Reviews became part of the daily practice of health care. According to a few interviewed physicians, some physicians are actively involved by handing out personal cards to their patients to let them know that they could place a review on Zorgkaart Nederland. In this way, the physician is getting more reviews. The negative side of actively collecting reviews is that physicians could give their personal cards to patients who were satisfied with their services and not to patients who were not satisfied.

However, not only handing out personal cards is a remarkable change because of online reviews on Zorgkaart Nederland. The empowerment of patients is another aspect that plays a role in the shaping of daily activities. The hierarchy between physicians and patients has changed over the years. For example, one interviewed physician said that physicians were no longer one of the most important people in the village. Instead, patients and physicians are now considered equals. Regarding such empowerment, physicians had different opinions:

"I always say to my patients, 'I am not a person with more power than you. I, as your physician, give you advice, and it is your turn to do something with that advice.'" (Physician Y1)

"Health care is transforming in a candy shop in which patients can walk around, looking for anything they need with the lowest costs." (Physician Y2).

Patients' needs are increasing in importance, and they no longer merely trust the words of a physician. Most of the time, patients want to see the words of physicians match the results of, for example, a physical examination, radiograph or a brain scan. In addition to the daily practices of physicians, each of the interviewed physicians reported having an extra job, such as a board member or member of a committee. These extra responsibilities, together with telephonic consults, e-consults, and additional administrative tasks, can put pressure on physicians. With these added pressures, physicians may sometimes not be mentally available in a consult, potentially resulting in a negative review. Such negative evaluations could, in turn, lead to more work pressure or, in the worst case, burnout. Besides patients' role in this, health insurers could also contribute to such burnout, according to the physicians: Patients require

more physical examination for less money, but health insurance companies require more mental and physical care in the same time for the same amount of money.

4.4 The role of Zorgkaart Nederland

The interviewed physicians were not actively involved or interested in Zorgkaart Nederland. Through in-depth questions about why physicians dislike Zorgkaart Nederland has become clear that Zorgkaart Nederland only has a small role in the daily practices of physicians resulted in the following unintended or unexpected aspects.

4.4.1. Publication bias

A common negative aspect of Zorgkaart Nederland pertained to the influence of publication bias as a human characteristic. According to the interviewed physicians, patients are more inclined to review something when they experience something negative. When a physician only has a few reviews on Zorgkaart Nederland, patients look only at the bad reviews. This is problematic for physicians because not all satisfied patients write reviews on sites like Zorgkaart Nederland. Physicians work hard to meet all patients' needs. When patients on Zorgkaart Nederland review them anonymously, physicians cannot say or do anything back. As a result, the problem cannot be solved. In this way, daily practices cannot be improved. This problem is further discussed in section 4.4.3.

The interviewed physicians said they were aware of patients who search actively for sites where they can openly review their physician or other health care providers to let other patients know about their experience. Apparently, there is also a special website where angry or unsatisfied patients can share their physician's data, including full name and address. Thus, patients can go far beyond social boundaries to let the rest of the country know about their bad experiences. One physician said he believed that some patients were always dissatisfied and that there are patients that are always satisfied.

4.4.2. Reliability of review

Another important aspect is the reliability of reviews. Patients can write their reviews anonymously, and some physicians believe that patients are not qualified to assess physicians' qualities. Conversely, anonymity may allow positive reviews to be written by physicians' co-workers or relatives. Another way to manipulate the online evaluation on Zorgkaart Nederland

is by only recommending the website to a satisfied patient. As a result, Zorgkaart Nederland may not have neutral and reliable evaluations.

Other physicians explained that Zorgkaart Nederland did not accurately reflect patients' real experiences because a review can be based on many different factors, such as the appointment with the physician, the treatment by the physician, the work relation between physician and other employees, the listening skills of the physician, and the accommodation of the hospital. According to the interviewed physicians, the first factors are good for reviewing a physician, but a physician cannot be punished because of bad accommodation.

In addition to the factor that is just discussed, communication or listening skills is another rating factor. When discussing this, the physicians said that they were reviewed not only on their medical knowledge but also on their communication skills. Therefore, when physicians do well on medical issues but poorly in communication, they may receive a bad review. Alternatively, in a consult with a patient, the physicians must look at the outcomes or other important information about their patients on the computer screen. Not every patient consult consists of 100% eye contact. Every patient needs a different level of social interaction with a physician. The interviewed physicians said that if patients were not satisfied with them, they would rate every factor poorly because they wanted to cause the overall rating of the physician to be bad. As a result, these reviews are not valid, and the physicians stated that the reviews were not nuanced enough. In the case of doubtful reviews, no conversation could be requested because of the anonymity.

4.4.3. Accessibility of review

Not every review is written anonymously. However, although the reviewed physician or hospital can request the contact information of a reviewer, it is most often not possible for a reviewed physician to get in touch with the patient who writes the review. When it is possible to get in touch with patients, the physician may meet with the patient and, most of the time, also with a mediator. These mediators are from the patient complaint department of a given hospital. The interviewed physicians said that most of the complaints can be explained. Conversations about complaints should be discussed in real life and not on a website such as Zorgkaart Nederland. They believed that most unhappy patients just want to be heard. In a face-to-face conversation, patients can express their feelings and can say what bothers them.

"I am a physician in this hospital who is known for the 'longer than planned' consults. This might annoy other patients. I assure other patients that these delays will not affect their consult with me, and I always explain a little bit the reason of the delay. In this way, I rarely have an unsatisfied patient because of the delayed appointments." (Physician X1)

4.4.4. Vulnerability of physicians

As a result of online review sites, the vulnerability of physicians is another important factor to consider. Beforehand of a first consult, patients already know much about their physician because information about them is public. If a patient screens a physician beforehand, it might result in prejudice, which could sometimes be misplaced. Patients could visit their physician with an incorrect image of him or her. Thus, the online reflection of a physician could be an inaccurate representation of reality. On the other hand, physicians know that many things are publicly available to everybody. Moreover, when a physician is a suspect in a disciplinary case, the full name of the physician is visible for everybody.

Another aspect of the vulnerability of physicians is that not all physicians can fit with all their patients. When physicians have a bad connection with one of the patients, there is an increasing likelihood, according to the physicians, that a patient will write a (bad) review on sites like Zorgkaart Nederland. A bad review could hurt a physician and make them doubt their professional skills. This is bad for their professional development. On the other hand, it is good that patients have the ability to share their experiences with other patients. Patients either have a connection with their physician from the first second or not. That is not unusual; it is human.

"I always say when you don't have faith in your doctor, look for another one. Your body is important. So, if the feeling is not right, look for someone else." (Physician X1)

Another physician said that criticism is good because everyone has something to improve. This means that this physician is open to receive some feedback because everyone can improve some things about himself. However, it is important to communicate these opportunities for improvement in the right way to the right physician. A patient can also be placed with the wrong physician because many physicians have specialties. The mission of Zorgkaart Nederland is to help patients find the physician with the specialty and characteristics that best meet their needs. In this regard, patients are no longer looking for the closest hospital but instead for the best physician for their medical complaints.

The interviewed physicians stated that a bad review goes online quickly. When a review is online, a physician cannot do anything about it. If a patient has a bad experience with a physician and if they share that experience with others online, it becomes publicly visible. Although physicians can react to reviews on Zorgkaart Nederland, the reviews remain nonetheless. In addition, not every patient of a physician writes a review about that physician. This results in the evaluations on Zorgkaart Nederland inaccurately reflecting the real work of the physician.

"As a physician with public reviews, you are kind of 'aangeschoten wild', everybody can say about you what they want. As a physician, you do everything you can. Sometimes, a patient cannot be saved." (Physician Y8).

According to another physician, physicians are not only people with good medical knowledge; they also are human beings with human brains. This aspect cannot be taken away. For example, one person cannot always be smiling or always be nice. Everyone can have a bad day, including physicians. In the worst-case scenario, a patient could destroy a physicians' career with a bad online review. For example, some interviewees mentioned the documentary about Tuitjenhorn, a general practitioner whose career was destroyed because of a mistake that was amplified by the media.

4.4.5. Expectations of patients

The last reason of the small role of Zorgkaart Nederland in the shaping of the daily practices in a hospital, according to the interviewed physicians, are the expectations of patients. Bad reviews could be the result of the misplaced expectations of patients. According to the interviewed physicians, patients do not only review the consult. They also take into account the quality of the food, waiting time, and whether they like their physician. In that latter case, it is possible for patients to change physicians. Each physician is his or her own person with a unique character. This also applies to patients. The combination of two different characters can fit between the characters of the physician and the complaints and characters of the patient. For example, one person may prefer a short consult, while another may prefer an extended consult.

It is good for every person to know their positive and negative characteristics. Sometimes, physicians are not familiar with a bad or good character trait. As a result of reviews on Zorgkaart Nederland, physicians can acknowledge their character traits. In addition, patients and other interested people can create a positive image of the team composition of a hospital, of a hospital

department, or of a physician. In extreme cases, bad physicians could be removed from the team – not every physician wants to change their negative characteristics.

However, there is also the concept of a 'second opinion', which is most often from a second physician from another hospital. A patient may want to know if there is really nothing else a physician can do if they receive a bad diagnosis, or a patient may want to know if the physician is right that there is no bad diagnosis. Most of the interviewed physicians acknowledged that ranking sites like Zorgkaart Nederland are the future. People, especially physicians, must be open to receiving feedback and improving their characteristics.

All the above-mentioned aspects are reasons of physicians that explain why the physician is not interested in Zorgkaart Nederland. Because of the publication bias, the reliability of a review, the accessibility of a review, the vulnerability of physicians are the expectations of patients are all reasons why practices do not change or improve according to the interviewed physicians. With these negative aspects, physicians are not motivated to change their characters. This does not result in new or improved knowledge that could be shared with other physicians or between hospitals to improve healthcare for the patients.

5 Discussion

The main goal of this research was to analyse how Zorgkaart Nederland shapes the daily practices of physicians in two Dutch hospitals. The daily practices of physicians consist of many different tasks: the outpatient clinic care, the treatment room, emergency service, and telephonic consults and e-consults. Ranking sites are growing in popularity, including for hospitals. Zorgkaart Nederland is an online ranking site on which patients can share their experience with a certain physician or with another health care provider with other patients. Hospitals deal with the increasing online reviews by setting up committees and steering groups to govern the process of information collection, and quality managers' report the data to external sources (Wallenburg, Quartz, & Bal, 2016). Such daily practices can be discussed in light of the practice theory of Nicolini (2012). Practices are needed to understand the world. Nicolini (2012) used an example of a classroom in which three important aspects define the classroom. This approach is also possible with regard to consults with physicians: 1) The participants are the visiting patients, 2) the practices are the actions of the physician in forming a treatment plan or in conducting a physical examination, and 3) the objects are any instruments that are needed.

Above mentioned practices are the basic units to run a hospital. The most important objects in a daily practice of a physician are the patient, the instruments to treat a patient and other smaller instruments or devices that are also needed to accomplish a good consult with a patient. The consult can be in an outpatient clinic care, in a treatment room, in the emergency service or with a telephonic- or e-consult. The objects connect different practices and participate to accomplish the daily practices of the physician. The connection of different practices also connects different physicians that can share their knowledge with others. This shared knowledge can also lead to new innovative knowledge. The public reviews of Zorgkaart Nederland result in some competitive practices between physicians to give patients the best care they need.

This research found a few aspects that changed through the arising of Zorgkaart Nederland. A characteristic of the practice theory of Nicolini (2012) is that practices give participants the power to do things and to think of themselves in certain ways. This can result in competitive practices by keeping the practices up to date. This characteristic of Nicolini (2012) can be compared with the result of this research that stated that some physicians participate by collecting many reviews by handing out personal cards to their patients. Some physicians manipulate this system by only asking satisfied patients to write a review on Zorgkaart Nederland. In this way, negative reviews can be correcting and can cause the main

value to rise. The reviews become part of the practices of physicians and Zorgkaart Nederland is added as a part of the healthcare. According to Wallenburg and Bal (2018), this phenomenon of manipulation is called 'playing the game', which consists of viewing something like a competition that can be won and that provides joy when one does well. In this regard, Zorgkaart Nederland can be seen as a competition between hospitals or as one between physicians. However, this is not the goal of Zorgkaart Nederland. Instead, Zorgkaart Nederland was established to help patients find the physician who best meet the patients' needs.

Another aspect that changed through the reviews on Zorgkaart Nederland is the empowerment of the patient. The interviewed physicians were dissatisfied with the increasing empowerment of patients in the hospitals. Patients want more physical examination, more research, and more photos because they no longer trust the word of their physician. The interviewed physicians stated that the one-way interactions of the review on Zorgkaart Nederland are a cause of this consequence: Patients can do and say anything they want, but physicians cannot say anything. Thus, the empowerment of the patient is not only about the needs and wants of patients but also about the reason that patients can speak freely in a review about a physician (Williamson, 2006; Mulgan, 2000; Grand & Keohan, 2005). Furthermore, healthcare insurers also play a role in this because they expect physicians to see more patients and to deliver more service in the same amount of time and for the same amount of money. Such empowerment can lead to unintended consequences for physicians – for example, causing them to focus more on quality research and intensive activities to achieve positive reviews. These measurements can take the place of other more important measurements related to the physicians' main task: taking care of their patients (Scott & Orlikowski, 2012).

With more in-depth questions about Zorgkaart Nederland, the interviewed physicians have a few reasons why the patient does not allow the reviews on Zorgkaart Nederland shape their daily practices in a hospital. First, the physicians believed that publication bias caused patients to share negative experiences more often than positive experiences. Second, the physicians questioned the reliability of the reviews, such as whether they were fair and written by real patients. An important factor pertaining to the reliability of reviews was considered to be the content of the review. In this research, the interviewed physicians believed they are mainly reviewed by patients on their communication skills instead of their medical knowledge. This is in line with a study by Maassen (2016). Maassen (2016) wrote an article about some positive and negative aspects of Zorgkaart Nederland. Third, after placing the reviews online, patients are most of the time not accessible to explain their evaluation or to talk with the

reviewed physician. Fourth, the physicians reported becoming more vulnerable because of these reviews and because of their reviewers' prejudices. Finally, the physicians were not happy with Zorgkaart Nederland because of the unrealistic expectations of patients, which influence their reviews on Zorgkaart Nederland. In real life, people sometimes simply do not fit with another person. The same is true in a hospital consult. Some patients do not fit with their physician. Nevertheless, this does not always have bad results; sometimes, this is the right way to treat people. Other times, it is not. All these reasons summarize the most critical opinions of physicians about reviews on Zorgkaart Nederland. With these reasons why physicians are not interested in Zorgkaart Nederland, new or improved knowledge cannot be shared with other physicians or between hospitals to improve healthcare for patients. The sharing of knowledge is one of the characteristics of the practice theory of Nicolini (2012).

According to Wallenburg and Bal (2018), these reasons are in line with the 'ignoring the game', a reaction of gamification in their research. Gamification refers to the play-like character of social interactions, supported by datafication of care that formed the playing area. The playing area in this research is the hospital. The gamification theory of Wallenburg and Bal (2018) consists of three different reactions: playing, ignoring, and changing. In this research, the most common response of the physicians is 'ignoring the game'. Almost every physician was not interested in Zorgkaart Nederland, did not look at the website, and did not talk about the website. The interviewed physicians were not satisfied with Zorgkaart Nederland, but they also did nothing to improve the ways that Zorgkaart Nederland could integrate with the daily practices of physicians. This is in line with the research of Waring (2007), which identified ways that physicians resist external quality regulations. Other ways that the interviewed physicians ignore the game include not discussing Zorgkaart Nederland with each other in meetings and not adjusting their practices in their consults with patients. Besides that, almost every interviewed physician reported not handing out cards to their patients in order to receive more positive reviews on Zorgkaart Nederland. In contrast, the physicians instead reported being involved in the development and improvement of internal performance measurements, and they were not concerned with external measurements. This is in line with the research of Wallenburg and Bal (2018). Nevertheless, most interviewed physicians can imagine the growing importance of Zorgkaart Nederland in the future, but before that can happen, the number of reviews must increase.

The results of this research are not fully in line with the results of Wallenburg and Bal (2018), who concluded that the collection of data about different practices evokes different gamification reactions. Their research suggests ways that practitioners can change their performance based on the three different reactions of gamification: ignoring, changing and playing the game. Conversely, this research about the role of Zorgkaart in shaping of daily practices suggests that most physicians do not prefer Zorgkaart Nederland as a performance measurement. Most of the physicians are 'ignoring the game', and a few physicians are 'playing the game' by manipulating the system of Zorgkaart Nederland.

The results of this research are also not in line with the results of Wallenburg and Bal (2018), because their research about gamification is more based on the human aspect of practices. The practices in this research are based on Nicolini (2012), which focused more on the non-human aspect of practices. The daily practices of physicians are not based on the physician, but on the practices of the physician.

Kleefstra (2016) also conducted research into performance measurements in hospitals, but from the perspective of patients. She concluded that sites like Zorgkaart Nederland are increasing in importance and that hospitals must create a positive profile by responding quickly to reviews by patients. Patients search on the internet to find helpful information about their physician or hospital. This conclusion is in line with the mission of Zorgkaart Nederland and was the impetus behind this research. In addition to the positive aspects noted by Kleefstra (2016), she also identified some negative aspects from the physicians' perspective, some of which are in line with the results of this research. For example, the physicians in this study were not enthusiastic about Zorgkaart Nederland, which is in line with the expectations of this research. Mainly negative opinions about Zorgkaart Nederland were expected because of the effect of such reviews on the vulnerability of physicians and because of their lack of reliability.

6 Conclusion

In this world, ranking is increasing in importance. In each business sector, a performance measurement system exists, including in the health care sector. In the Netherlands, the Federation of Patient and Consumer Organizations (Nederlandse Patientenfederatie) developed Zorgkaart Nederland for patients. The mission of Zorgkaart Nederland is to give patients the opportunity to search for and share experiences regarding health care providers. Patients can rate their experience with a physician on the following factors: appointments, accommodation, employees, listening, information, and treatment (Zorgkaart Nederland, 2019). With a special subscription, hospitals or other healthcare providers can react to and manage the reviews of patients on Zorgkaart Nederland. Zorgkaart Nederland has existed for 10 years and already has many critics. In this research, the role of Zorgkaart Nederland in shaping the daily practices of physicians is explored. This research answered the following research question: *How does Zorgkaart Nederland shape daily practices of physicians in Dutch hospitals?*

The goal of this study was to explore if Zorgkaart Nederland plays a role in shaping the daily activities in Dutch hospitals. Data collection consisted of an exploratory case study including interviews with physicians with different specialties at two medium-sized regional Dutch hospitals. The research question is mainly answered based on the practice theory of Nicolini (2012). Zorgkaart Nederland does not shape the daily practices of a physician.

Most physicians were not enthusiastic about Zorgkaart Nederland, and they expressed more negative than positive opinions. However, some changes are observed by the interviewed physicians. First, manipulation by asking only satisfied patients to review the performances of the physician. In this change, reviews are a part of the daily practices of a physician and Zorgkaart Nederland is added as a part of healthcare. Another change is the empowerment of patients. Patients are asking for more care, and health insurances are supporting them. Both parties want more practices for the same amount of money and time. These two changes are in line with the reaction of 'playing the game' of Wallenburg and Bal (2018).

Except for these changes, also a few negative aspects of Zorgkaart Nederland are mentioned, such as the negative publication bias of patients. Patients preferred to write a review about their physicians when their experience was negative and not when their experience was positive. Second, the reliability of some reviews is questionable. Physicians can also ask people who are no patients to write a review about their skills as a physician. Third, the accessibility of patients is an issue because they can write anonymous reviews. This results in physicians being unable to contact these patients to solve their issues. In addition to the reasons as

mentioned above, the vulnerability of physicians was the last reason that was mentioned multiple times as a negative effect of Zorgkaart Nederland – especially the fact that all reviews are publicly open. Moreover, the expectations of patients have an undue influence on the number of reviews. A patient and a physician cannot fit their character, or the mood of a patient can be changed by other factors in the hospital. According to the interviewed physicians, these reasons are the cause that Zorgkaart Nederland is not shaping the daily activities of Zorgkaart Nederland. Because of these reasons, the knowledge of physicians by practices cannot grow and healthcare cannot be innovated.

These negative opinions of physicians regarding Zorgkaart Nederland are in line with the reaction of 'ignoring the game' of Wallenburg and Bal (2019). The physicians do not talk or look about at Zorgkaart Nederland. Their attention is mainly on the internal performance measurement systems. In addition, some physicians find other ways to collect positive reviews of Zorgkaart Nederland by only asking satisfied patients to write a review on Zorgkaart Nederland. In this way, a distorted image appears, and the accuracy of Zorgkaart Nederland is thus questionable.

Kleefstra (2016) explored the patient perspective with regard to performance measurements of hospitals. She concluded that patients should be heard with regard to their experiences. In this research, the perspective of physicians is explored because physicians are not happy with patients' publicly shared experiences.

The limitations of this research are that only nine physicians were asked about Zorgkaart Nederland. In order to conduct a more reliable and valid study, more physicians should be interviewed. Most physicians likely care about this subject because they know that Zorgkaart Nederland will grow in importance in the future. In this regard, not only the voice of patients' is important but also that of physicians. Another limitation is that this research focused on two medium-sized regional hospitals. Results could be different in larger hospitals or in academic hospitals, which are mostly established in heavily populated areas, like the Randstad in the Netherlands.

These limitations hopefully will lead to future research options. Recommendations for future research would be to analyse other types of hospitals, such as bigger hospitals, academic hospitals or hospitals in a more densely populated cities, such as Rotterdam and Amsterdam, where patients can choose between hospitals. Additionally, a higher number of physicians with wider-ranging specialties should be interviewed in order to conduct a more valid and reliable study about Zorgkaart Nederland. Future research of the daily practices of physicians, related to online reviews, could result in a more appropriate representation of Zorgkaart Nederland.

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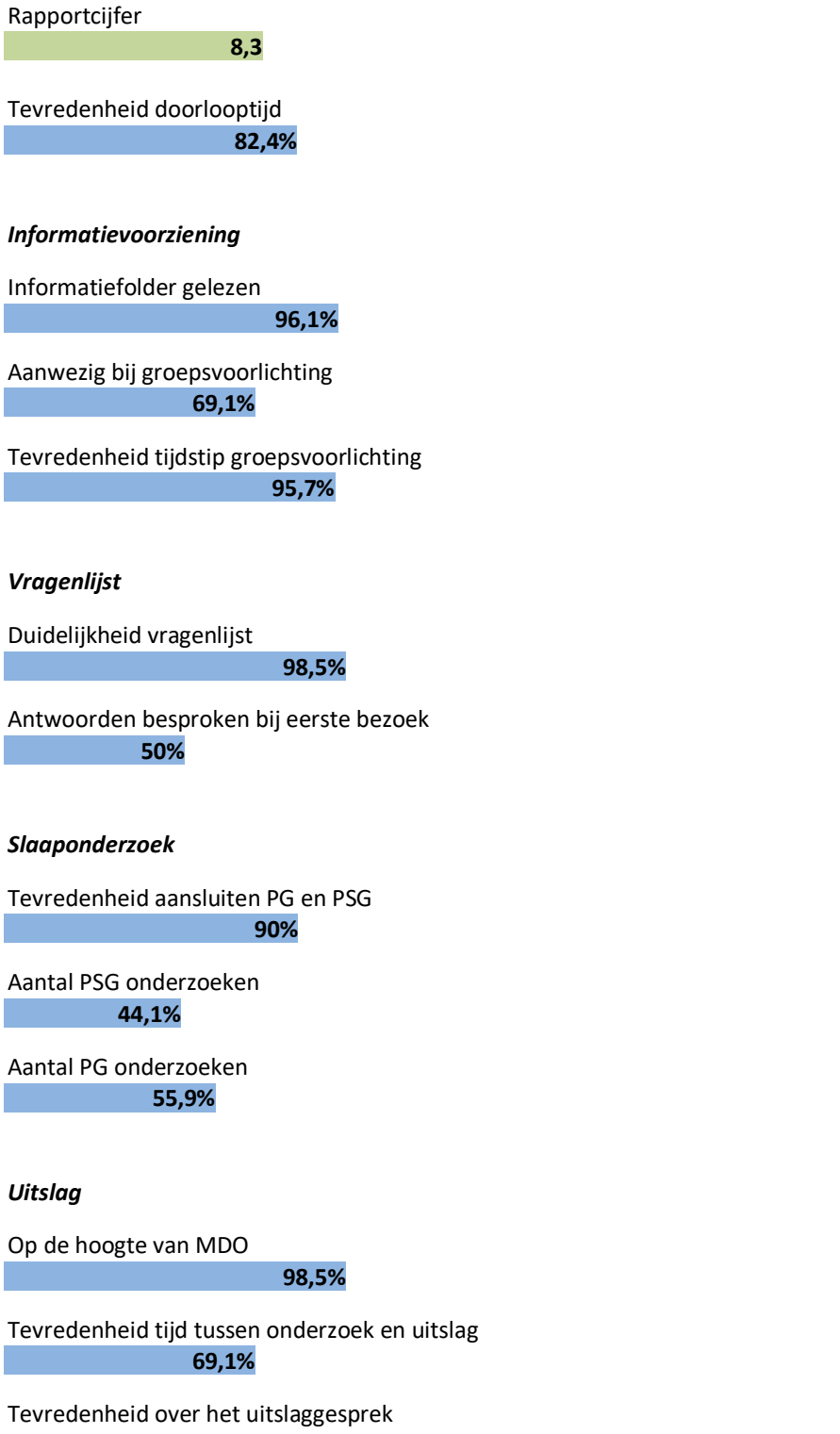
Appendix

Appendix A

Resultaten Feedbackradar Slaapcentrum
Meetperiode : 6-11-2018 t/m 19-4-2019
Aantal ingevulde vragenlijsten: 68 (respons 56%)



Tevredenheid traject van verwijzing tot uitslag is te lang of veels te lang

Afsluiting

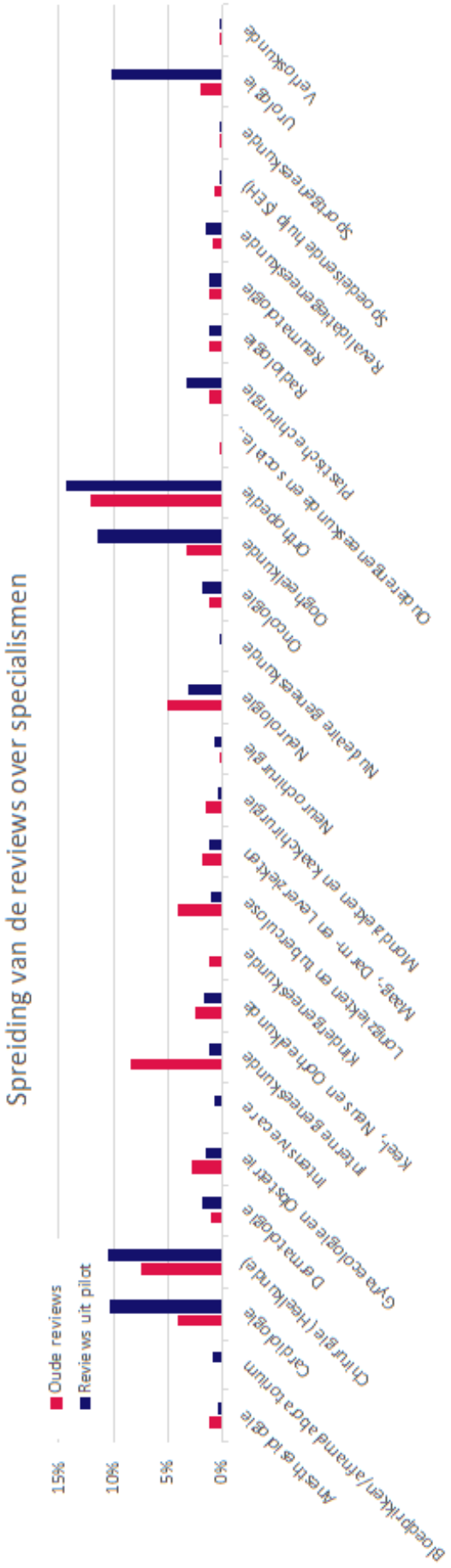
Tevreden én zal dit actief uitdragen naar anderen

Tevreden over bezoek slaapcentrum

Appendix B

Appendix C

Appendix D


Spreiding van de reviews over specialismen
Oude reviews
Reviews uit pilot
15%
10%
5%
0%
Bloedproblemen/Anemie
Anesthesiologie
Cardiologie
Chirurgie (Hematologie)
Dermatologie
Gynaecologie en Obstetrie
Interne Geneeskunde
Keel-, Neus en Oorheelkunde
Kindergeneeskunde
Longziekten en tuberculose
Maag-, Darm- en Leverziekten
Mond-, Kaak- en Aangezichtschirurgie
Neurochirurgie
Neurologie
Nucleaire Geneeskunde
Oncologie
Oogheelkunde
Orthopedie
Plastische chirurgie
Radiologie
Reumatologie
Revalidatiegeneeskunde
Spoedeisende hulp (EEH)
Spoedgeneeskunde
Urologie
Verloskunde

Appendix E

Interview vragen master thesis Zorgkaart:

Beste meneer/ mevrouw …,

Allereerst hartstikke bedankt voor uw tijd en moeite voor mijn onderzoek naar Zorgkaart Nederland. Met dit onderzoek wil ik graag analyseren welke rol Zorgkaart speelt in de dagelijkse werkzaamheden en of activiteiten van artsen.

Misschien bent u al bekend met Zorgkaart Nederland. In het kort is Zorgkaart Nederland een online waarderings- website voor zorgverleners in Nederland. De waarderingen worden uitgevoerd door patiënten.

Ik heb voorafgaand aan dit interview nog een paar voorbereidende vragen voor u:

- Wilt u inzicht krijgen in het uitgewerkte interview en of in de resultaten van mijn onderzoek?
- Dit interview vindt volledig anoniem plaats. Uw naam en het ziekenhuis komen onder een andere naam voor in mijn onderzoek, bijvoorbeeld arts X en ziekenhuis X. Met alle informatie wordt vertrouwelijk omgegaan en niet gedeeld met derden. Hiernaast wordt de opname veilig opgeslagen.
- Vind u het goed als dit interview opgenomen wordt? Dit helpt mij met het transcriberen en coderen van het interview en daarbij bij het analyseren van Zorgkaart Nederland.

Inleiding

Zullen we elkaar eerst even introduceren voordat we met het interview beginnen?

Allereerst hartstikke bedankt voor uw tijd en moeite voor mijn onderzoek naar Zorgkaart Nederland. Mijn naam is Sophie Bierens en ik studeer de master Accounting and Control aan de Radboud Universiteit Nijmegen. Ik schrijf op het moment mijn master thesis voor het afronden van mijn studie. Zoals u misschien in mijn onderzoeksopzet hebt kunnen lezen, ben ik naast accounting ook erg geïnteresseerd in de zorg. Daarom vind ik het erg leuk en interessant om op deze manier een kijkje te nemen in het doen en laten van artsen in een ziekenhuis.

Ik wil u graag nog vermelden dat alles wat hier verteld wordt tussen u en mij blijft. Uw naam en het ziekenhuis wordt anoniem vermeld in mijn onderzoek. We beginnen het interview met een paar inleidende vragen, waarna de rest van de vragen over Zorgkaart Nederland volgen.

Vragen

1. Kunt u uw dagelijkse werkzaamheden voor mij beschrijven? Bijvoorbeeld hoe ziet een dag van u er gemiddeld uit als u ’s ochtends het ziekenhuis binnenloopt?
2. Wat is uw leeftijd? (I.v.m. deelvraag onderzoek)
3. Hoelang werkt u al in dit ziekenhuis?
4. Heeft u nog andere functies naast uw functie als arts? Zo ja, welke...
5. Welke taken horen bij deze functie? (Kijken i.v.m. vraag 4 in hoeverre beantwoord)

Vraag 6,7 en 8 hangen af van het antwoord van vraag 1, 4 en 5

6. Hoe ziet een consult met u als arts er in het algemeen uit?
7. Op welke manier communiceert u met uw patiënten tijdens en buiten het consult?
8. Welke procedures gebruikt u tijdens een consult met een patiënt? – Protocol, geen protocol of iets anders.

9. Is er een systeem dat de kwaliteit van de zorg waarborgt? (Protocollen?) Worden er prestaties gemeten in dit ziekenhuis? Extern/Intern. Zorgkaart is extern.
10. Wat vindt u van prestatiemetingen binnen dit ziekenhuis?
11. In de steeds meer ‘online’ wereld, staat veel informatie op internet en is beschikbaar voor een grote groep mensen. Bent u bekend met Zorgkaart Nederland?
12. Zo ja, ...
13. Zo nee, …

Zorgkaart Nederland is een onafhankelijk online platform van patiënten federatie Nederland. Via dit platform kunnen patiënten laten zien hoe andere patiënten de zorg bij een bepaalde hulpverlener waarderen. In de praktijk blijft dat Zorgkaart Nederland een goed hulpmiddel is voor klanten die zich oriënteren op een keuze tussen verschillende zorgaanbieders. Waarderingen van zorgverleners of aanbieders geven patiënten de mogelijkheid om zelf hun keuzes te maken, maar ook ervaringen te delen (Inkoopbeleid Huisartsenzorg 2020). VGZ is een voorbeeld van een zorgverlener, dat hun cliënten adviseert om patiënten erop te wijzen dat zij hun waardering kunnen geven via Zorgkaart Nederland.

14. Wat zijn uw ervaringen met Zorgkaart Nederland?
15. Wat vindt u van Zorgkaart Nederland?
16. Wat zijn volgens u de belangrijkste doelen van Zorgkaart Nederland? (Even kijken om dit wel te vragen).

17. Wat zijn volgens u de positieve en of negatieve punten van Zorgkaart Nederland? Zou u met deze punten wel of geen gebruik maken van Zorgkaart Nederland?
18. Wat is volgens u de reden dat Zorgkaart Nederland wel of niet werkt?
19. Kunt u dit met een **voorbeeld** beschrijven? Hoe is hier intern mee om gegaan?
20. Indien u niet tevreden bent over Zorgkaart Nederland, wat is volgens u een goede manier om naar de belangen en wensen van de patiënt te luisteren?
21. Bespreekt u Zorgkaart Nederland onderling met andere artsen? Kunt u dit misschien **beschrijven**?
22. Wordt er intern vanuit het ziekenhuis aangespoord om patiënten Zorgkaart te laten interviewen?
23. Wat vindt u van het feit dat de waarderingen openbaar en online te vinden zijn?
24. Vindt u van de stelling dat de kwetsbaarheid van artsen wordt aangetast door Zorgkaart Nederland? Als ik hierbij **een beeld probeer te vormen**, waaraan kan ik dan aan denken?
25. Houdt u zelf veel rekening met Zorgkaart Nederland? (Ik zag dat u … beoordelingen had, met een gemiddelde van …). Kijkt u veel op Zorgkaart Nederland? Wat doet u met uw beoordelingen op Zorgkaart Nederland? Bent u soms met Zorgkaart Nederland bezig als u patiënten ziet?
26. Worden er interne meetings gehouden? Komt het ter sprake in vergaderingen? Op welke manier komt het terug in de dagelijkse praktijken?
27. Heeft u het idee da tu rekening houdt met de waarderingen op Zorgkaart als u patiënten ziet? Denkt u er wel eens aan? Zou het kunnen zijn dat, artsen in het algemeen, wellicht andere keuzes kunnen maken of ander gedrag vertonen door de komst van Zorgkaart? Hoe ervaart u dat of hoe denkt u hierover na?
28. Ik zou graag dit interview willen afronden. Heeft u nog vragen naar aanleiding van dit interview? (Eventuele benoemde documenten: kan ik de benoemde documenten krijgen) **– Open notulen van vergaderingen misschien?** Weet u misschien nog andere artsen die ik hierover mag interviewen?
29. Mag ik nog contact met u opnemen als ik nog vragen hebt na het uitwerken van het interview?

Afsluiting

Bedankt voor uw tijd voor dit interview. Ik hoop dat u dit interview als prettig heeft ervaren. Heeft u nog op of aanmerkingen over dit interview of het onderwerp van dit interview?