Accountability in healthcare

Searching for a balance between feeling responsible and being held accountable

A research into how accountability impacts the tasks and duties of doctors

Master's Thesis Organizational Design & Development

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"Out of clutter, find Simplicity. From discord, find Harmony. In the middle of difficulty lies Opportunity."

– Albert Einstein

When I started writing the thesis at the beginning of 2019, I actually did not know exactly where it would lead, what I would write and what would come out. Now the end is here. Writing the thesis was not always easy and the above quote expresses it well. There were some moments when I could not find any logic, simplicity or saw any opportunities. It was sometimes difficult to find structure through all material and data. In the end I am proud of the results and here for I would like to thank my supervisor Dr. C. Groβ in particular. Her feedback and advice challenged me to look beyond the given lines and literature. Try to find a solution yourself in difficult situations. With her passion and focused feedback, I was able to take my thesis further at times when I was no longer able to do it myself. I also want to thank my second supervisor, Dr. D.J. Vriens, for his feedback and advice. I would also like to thank all the professionals in different hospitals around the country. Despite their busy schedules, they were able to find some space and time to talk with me. It is admirable to see with how much passion and skills they perform their work. Finally, I would like to thank my family and dear friends for the support and trust.

Thank you!

Marleen Cornelese

Abstract

Over the past few years, a trend has developed that professionals in various sectors have to justify their actions to a wide audience (Vriens, Vosselman and Groβ, 2016). This also counts for medical professionals in healthcare. Accountability is a subject that cannot be ignored anymore by doctors in hospitals. At this time, three different forms of accountability are elaborated in literature: calculative, narrative and conditional accountability. These three forms of accountability all have their own advantages and disadvantages. Vriens et al. (2016) elaborate these three forms, but there has not yet been done a research where the three forms of accountability are taken together to investigate the impact on the tasks of professionals.

Given the importance attached to accountability in the work of professionals, and given the lack of empirical evidence on the relationship between the different tasks of doctors and the different forms of accountability, the focus of this thesis is on the impact of the three forms of accountability on the tasks and duties of doctors. These theoretical advantages and disadvantages of the three forms, and the different task groups of doctors are operationalized in a conceptual model in order to develop an interview guide. The interviews were conducted among seven different doctors within hospitals. This interview guide assesses the different tasks of doctors and how the three forms of accountability have an impact on these tasks. With the results, the following research question will be answered: "*How do doctors perceive the impact of the three different forms of accountability on their tasks and duties?"*

The results of the interviews showed that the three forms of accountability have negative and positive effects on the tasks of doctors. It also provided an interesting insight into the perspective of doctors on the concept of accountability and showed a contradiction between the concept of accountability and responsibility. By this, the insights of this research are a starting point for discussion in organizations about in what way the three forms of accountability are present and how they are perceived by professionals to serve best related to their tasks.

Keywords: Professional accountability, health care, calculative accountability, narrative accountability, conditional accountability, responsibility, medical professionals

Contents

1. Introduction

Over the past few years, a trend has developed that professionals in various sectors have to justify their actions to a wide audience (Vriens, Vosselman and Groβ, 2016). This implies that these professionals "should be accountable for the effectiveness of the services they deliver" (Banks, 2004, p.151). Currently, there are two existing forms of accountability: calculative and narrative accountability. Vriens et al. (2016) developed a third suggestion of accountability, the conditional approach. The way of accounting that is frequently used is 'calculative accountability', where the professionals are asked to give an account that abstracts from the specific situations professionals have to respond to (O'Neil, 2002). In hospitals for example, calculative accountability is when doctors show how many of their patients (in terms of numbers of percentages) went home healthy in order to realise a certain target that is set by the hospital or governance. With this form of accountability, work and performance are regulated and prescribed in detailed instructions (O'Neill, 2002). It focuses on results, standard procedures, protocols and norms. These calculative measures are easy, cheap and simple to make visible to the public. However, calculative accountability measures do not fully capture professional work (Vriens et al., 2016). 'Each profession has its proper aim, and this aim is not reducible to meeting set targets, following prescribed procedures and requirements' (O'Neill, 2002, p.13). One common problem is that they provide a decontextualized account, but calculative accountability is also said to create alienation, decreased professional responsibility, instrumental behaviour, perverse incentives and a lack of empathy (Vriens et al., 2016). Therefore, the measures are disturbing the aim of professional practice and damage professional pride and integrity (O'Neill, 2002).

Next to the calculative form of accountability there is the narrative form of accountability, where an account is not given in terms of pre-fixed categories, but in the form of explaining to and discussing with other reasons for conduct in a way that allows for freedom (Vriens et al., 2016). An example of this narrative accountability would be a doctor who –without necessarily referring to binding rules or targets – explains a diagnosis to a patient, discusses several alternative treatment, listens to possible objections, and arrives at a professional preference (Vriens et al., 2016). This narrative accountability has some advantages in contrast to calculative accountability. Narrative accountability provides contextualization and the possibility to have some form of dialogue. Professionals are able to communicate to each other about ideas, situations etc., and this is very profitable for the professionals. This

immediately addresses the disadvantages of narrative accountability. All this complicated information is difficult to understand for outsiders (Kamuf, 2007). This narrative form of accountability may not be sufficient in creating confidence to a wider public and by this there is a dilemma created of professional accountability. On the one side we need accountability and on the other side the current forms harm the professionals (e.g. Roberts 1991, 2009; Vriens et al., 2016).

The third form of accountability is the developed conditional approach. Vriens et al. (2016) propose an ideal-typical description of professional conduct as conduct with three characteristics: (1) it applies and further develops specialized knowledge, (2) it is intensive technology based on discretion and feedback, and (3) it is devoted to a societal value (Vriens et al., 2016). The conditional approach focusses only on the professional and takes the conditions for professional conduct as object of account. Just like with the former two forms of accountability, conditional accountability has some advantages. The conditional approach of accountability shows the degree to which goals are set for professionals and it enables the application and further development of professional knowledge. The intensive technology based on discretion and feedback enables context-specific diagnosis and treatment and finally (Vriens et al., 2016). The conditional approach of accountability also has some disadvantages. Organizations, institutions or the government should take care of the conditions needed by the professional in order to do their work properly, but this will not guarantee an ideal-type of professional conduct (Vriens et al., 2016). For example, in a hospital the conditions could be met but doctors could still perform poorly or show opportunistic or downright criminal behaviour. The conditional approach could also downplay other goals, like efficiency, profitability, uniformity and equity (Vriens et al., 2016).

So, there are three forms of accountability (calculative, narrative and conditional) and every form has its own advantages and disadvantages. These forms of accountability can be addressed within every organization and can be applied to every professional. One type of professional that has to account to a wide audience are doctors within hospitals. Doctors must be able to justify everything they do. But a doctor has many different types of duties, for example offering consulting hours to patients, performing physical checks, establish the diagnosis, preparation of a treatment plan, carrying out procedures, etc. These specific tasks could be summarized into two different task groups; direct patient care and indirect patient care. Next to the tasks on the patient level, doctors also must perform tasks on the level of the professional group, like meetings, consultations, discussions and evaluations with other

professionals within their professional group. At last, doctors also have to do documentation. The consulting hours with patients need to be documented, but also why doctors make certain choices in their procedures.

Becker, Kempf, Xander, Momm, Olschewski, and Blum (2010) have performed a case study where has been found that physicians spend 21,5% of their work hours on documentation. In their research they state that more communication between patients and relatives in hospital wards is needed (Becker et al., 2010). “Short doctor-patient communication make patient centred care more difficult which results in the physicians' dissatisfaction with their work (environment)” (Becker et al., 2010, p. 8). The Federation of Medical Specialists (2017) even found that doctors nearly spend 40% of their time on administrative work. More currently, in September of last year a news article appeared on a sample carried out by the Central Bureau of Statistics about the workload of people in the healthcare sector. A survey among 1.3 million people showed that the workload in the sector is increasing. The reasons given for this are the regulatory burden, administrative burdens, complexity of tasks, empowerment of clients and the lack of staff (Centraal Bureau voor Statistiek, 2019). Documentation is an obligation according to the Civil Code, but as already indicated above, doctors spend a long time on this and this leads to an increase in workload. Doctors have less and less space and time to provide good care (Van Heijst, 2011).

So, currently there two existing forms of accountability and one proposed approach within hospitals, each with its own advantages and disadvantages. Doctors also perform tasks within different task groups. Nowadays, accountability within hospitals is a topic that can no longer be ignored and doctors are experiencing more and more work pressure due to increasing regulatory pressure and administrative burdens. How do these different forms of accountability relate to the tasks of doctors and what impact do they have? It is relevant to investigate this linkage because there has been done research on the individual forms of accountability on professions, but there has not yet been done research on the combination of the three different forms of accountability on one particular profession, in this case doctors within hospitals. This combination on this particular profession is even more relevant because of all the commotion surrounding this profession when it comes down to work pressure due to the increased accountability demand.

The research question that arises here is:
"*How do doctors perceive the impact of the three different forms of accountability on their tasks and duties?"*

1.1 Objective and research question

It has become clear that accountability in healthcare is a subject that cannot be ignored by professionals. Doctors are obligated to account for their actions and made choices on different levels. This can bring along some problems for the professionals. For example, it is required that doctors need to systematically organize the quality of their work (KNMG, 2007) and literature shows that this can cause an increase in the workload. Also, there are a hundred different guidelines and protocols within hospitals that medical professionals must adhere to. A problem that could occur because of these guidelines and protocols is that they would reduce the workability and findability of doctors (Oms, 2013), it can create 'cookbook medicine' and unreal expectations (Grol & Wensing, 2011)

What also has become clear is that there are to existing forms, and one proposed form of accountability. Every form of accountability as described by literature form has its own advantages and disadvantages. Given the importance attached to accountability in the work of professionals, and given the lack of empirical evidence on the relationship between the different tasks of doctors and the different forms of accountability, the focus of this thesis is on the impact of the three forms of accountability on the tasks and duties of doctors. From this it can be investigated which form of accountability is necessary and of value for a certain task within the profession.

In order to fill the knowledge gap on the role of the different forms of accountability in relation to tasks in a specific profession, the research objectives are as follows:

Objective 1: To increase knowledge about the relation between the different forms of accountability and the different tasks of doctors in hospitals.

Objective 2: To uncover how doctors perceive the different forms of accountability and how these forms influence the perspective of doctors on their tasks.

This research will contribute to the dilemma of professional accountability, because different perspectives on the impact of the three different forms accountability on the tasks and duties from one professional will be investigated. From this aim, the following research question is developed:

"*How do doctors perceive the impact of the three different forms of accountability on their tasks and duties?"*

In order to achieve the objectives and answer the research question as stated above, an interview study will be done among doctors in different Dutch hospitals. With an interview study, different perspectives and opinions can be brought into light. The methodology of this research will be further elaborated in chapter 2.

1.2 Relevance

This research has both scientific as societal relevance. This study is scientifically relevant because it will fill the knowledge gap on the role of the different forms of accountability in relation to tasks in a specific profession. Because of the negative consequences that are argued in literature about the calculative and narrative form of accountability, a call for an intelligent form of accountability was created. Vriens et al. (2016) argued that the current forms of accountability (calculative and narrative accountability) may not be suitable as forms of public professional accountability and proposed the conditional approach. But every form of accountability has advantages and disadvantages, like is explained in the introduction of the research. The main aim of this research is to give insight in the comparison of the three accountability forms stated by Vriens et al. (2016) – calculative, narrative and conditional – related to the different tasks of doctors within the hospital. By this, an empirical elaboration can be done to the three forms of accountability. This is relevant because as is stated above, all the three forms of accountability are investigated separately. There has not yet been a research were the three forms are combined in relation to the tasks of a particular profession, the doctors. Despite the fact that the conditional form is a non-existing approach, it is interesting to investigate how doctors perceive the three forms because of the commotion around the work pressure doctors should experience due to the increased demand of accountability has not been investigated with the combining of the three forms on one particular profession.

This research will be societally relevant, because as described in the introduction of this research, professionals nowadays have to give account for almost everything they do. The outcomes of this research can give insights in the relation between the different forms of accountability and the different tasks of doctors in hospitals. The insights gained in this research can be the starting point for discussion in organizations about in what way the three

forms of accountability are present and how they are perceived by professionals to serve best related to their tasks.

1.3 Outline

In order to answer the research question mentioned in §1.3, this research paper is structured as follows. The second chapter of this research will provide a theoretical background with important information on accountability, the three forms of accountability and their advantages and disadvantages, a systematic summary on the three forms, accountability in healthcare and the different tasks of doctors. The third chapter, the methodology will be explained in which the research method, sample, data collection methods, data analysis, and the research ethics and limitations are elaborated. The fourth chapter will contain the analysed results in order to answer the research question. Finally, in chapter five, the research question will be answered in the conclusion. Also the theoretical and practical implications, limitations, recommendations and researcher's reflection will be elaborated.

2. Theoretical framework

In this chapter the theoretical framework is presented. In the first paragraph an explanation will be given of the term accountability. After this, in the next paragraph, the three different forms of accountability will be elaborated. In order to answer the research question, the three different forms of accountability will be explained and advantages and disadvantages are elaborated. In paragraph 2.3, accountability in the health care sector will be on the basis of the perspective of the manifest of medical professionalism of the KNMG (Koninklijke Nederlandse Maatschappij tot bevordering der Geneeksunde; Royal Dutch Society for the furtherance of Medicine). In the next paragraph, the different task groups of doctors will be elaborated. Finally, the last paragraph will contain the conceptual framework that will be used in this research.

2.1 What is accountability?

Now that it is clear what a professional is, it is important to fully understand what the term "accountability" entails. Over the past few years, a trend has developed that professionals in various sectors have to justify their actions to a wide audience (Vriens et al., 2016). But accountability is a concept that has not always been understood well. Schedler (1999) describes accountability as an underexplored concept whose meaning remains evasive, whose boundaries are fuzzy, and whose internal structure is confusing. Accountability has long been seen as a necessary, mandatory number for bookkeepers a lawyers where not much political honour can be gained (Bovens, 2005). Nowadays, accountability has been expressed as the core of public affairs; it has been developed into a much broader form of public accountability. Bovens (2007) states that accountability is a concept that no one can be against, but the evocative power of accountability makes it also a very elusive concept because it can mean many different things to different people. Bovens (2007, p.450) stays close to its historical roots and defines accountability as a specific social relation: "Accountability is a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences".

Behn (as cited in Bovens, 2007, p. 449) states that accountability often serves as a "conceptual umbrella" that covers various of other distinct concepts, such as transparency, equity, democracy, efficiency, responsiveness, responsibility and integrity. This also applies on doctors in hospital. Accountability for doctors in hospitals also covers several of other

distinct concepts. In addition, Koppell (2005) distinguishes five different dimensions of accountability – transparency, liability, controllability, responsibility, responsiveness – that are each icons and umbrella concepts themselves.

Messner (2009, p.919) argues that accountability is more than just the conventional definition of accounting. Messner (2009) argues that accountability takes place in social relations, including mutual responsibilities and identities of people.

Møller (2009, p.37) describes accountability as a multi-layered concept; "It defines a relationship of control between different parties, and has a connection to trust". Here a party or person needs to answer questions about what has happened within one's area of responsibility. Møller (2009) also states that accountability is an important dimension of professionalism. For example, a doctor is morally responsive to their patients and families, as well to the public through the mechanism of the state.

It has become clear that there are different definitions of the concept 'accountability'. For this research, the definition of Bovens (2007) will be used as a guide. This because this research also deals with an actor (doctor) and a forum (patient, hospital, society) and the actor also has a certain obligation towards this forum. So, accounting is a relationship between actor and forum, in which the actor has an obligation to explain and justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences. For this research, the three forms of accountability described by Vriens et al. (2016) will be used because in this way it is possible to examine and interpret different facets of accountability of doctors. These three models all have their own advantages and disadvantages that are stated in different articles.

2.2 Three forms of accountability

In the last few years, professionals have increasingly been called to account (cf. Banks, 2004; Evetts, 2001; Lunt, 2008; O'Neill 2002, 2013, 2014; Power 1994, 1997). Many authors are critical of the form and the extent of this professional accountability. At this moment, there are three forms of accountability as explained by Vriens et al. (2016): calculative accountability (§2.2.1), narrative accountability (§2.2.2) and conditional accountability (§2.2.3). In this section, the three different forms will be explained and their advantages and disadvantages will be elaborated.

2.2.1 Calculative accountability

Vriens et al. (2016) describe calculative accountability as the form of following procedures and rules or in the form of working to pre-determined targets or standards. Calculative accountability is a coherent concept of these two forms as argues by Vriens et al. (2016). O'Neill (2002, 2014) argues that we face a deeping crises of trust and states that trustworthiness is more than just reliability: "it is a feature of action which require conscious choice: for a person to be trustworthy, it is necessary that the person making a promise intends to keep that promise and that, when the times comes, the promise is kept in a reliable manner" (O'Neill, 2014, p.15). Accountability should be a remedy for trust, but O'Neill (2014) argues that this kind of remedy has taken an unintelligent form that sets standards for performance – targets – and then measures success though 'tick box' approach to the meeting of these targets. Møller (2009) states that this intelligent form of accountability tends to be related to the managerial accountability across the world, where scores and numbers are used as evidence. Kamuf (2007) also confesses this description of managerial accountability and states that it's about giving account through numbers.

Despite the fact that O'Neill (2014) argues that this kind of "remedy" has taken an unintelligent form, managerial accountability integrates well with managerial processes. It envisages that managers will set targets for individuals and institutions and that their performance will then be measures against those targets and sanctioned if inadequate (O'Neill, 2014). O'Neill (2014, p.177) argues that 'the simplicity of scores on performance indicators makes them easily aggregable into rankings and league tables that are useful for forms of transparency and openness that can supposedly be used to secure accountability to wider publics and to demonstrate the fairness of resource allocation and other decisions'. Clark (2000) even states that it is a professional duty to provide this clarity. Also Banks (2004) states that some form of transparency is needed – 'it should somehow become clear to the public that professionals are delivering the services they are supposed to deliver' (p.151).

This form of accountability also harbours several problems (Vriens et al., 2016). Vriens et al. (2016) argue that the most important problem of this form of accountability is that it forces professionals to give an account that abstracts from the specific situations professionals have to respond to, what is also called as decontextualization. O'Neill (2014) argue that this form of accountability has become an extension of managerial processes instead of examine managers for what they do. These chosen performance indicators provide simplistic and misleading proxies (such as the length of a hospital waiting list). They also

have the potential of creating perverse incentives (O'Neill, 2014). Such instrumentalism may lead to poor professional performance if the good thing to do in a specific situation no longer depends on context-specific discretionary professional judgement and dedication, but only on what the rules prescribe or on the targets that need to be reached (O'Neill 2002, 2014; Schwartz 2011 as cited in Vriens et al., 2016). Møller (2009) confirms this statement by arguing that it concerns the lack of validity of the outcome measure on which improvement is to be based and that instead of motivating for improvement, it will result in increased low performances.

In addition to the set targets with this form of accountability, this also includes established guidelines and protocols. The literature confirms that the above problems regarding the indicators and set targets are the same for the guidelines and protocols. The Order of Medical Specialists (OMS) (2013), states that workability and findability are reduced because there are so many guidelines and protocols. Secondly, it is possible to work in a too protocol-oriented way causing that the patient's uniqueness is not seen or heard (Goossensen, Baart, Bruurs, van Dijke, van Herwijnen, van de Kamp, and Kuis, 2014). Grol and Wensing (2011, p.160) name this the so called 'cookbook medicine'. Finally, protocols and guidelines can lead to unrealistic expectations, so that a desired result is always expected (Gros and Wensing, 2011).

In summary, these authors argue that these accounts do not do justice to and cannot fully capture professional decisional and actions (Vriens et al., 2016).

2.2.2 Narrative accountability

O'Neill (2002) states that one needs "less distorting forms of accountability" and there for some authors suggest to use 'narrative' forms of accountability (Etchells 2003; Kamuf 2007; O'Neill 2002). Vriens et al. (2016) explain that in such forms, an account is not given in terms of pre-fixed categories, but in the form of explaining to and discussing with others reasons for conduct in a way that allows for freedom. An example of this narrative accountability would be a doctor who –without referring to binding rules or targets – explains a diagnosis to a patient, discusses several alternative treatment, listens to possible objections, and arrives at a professional preference (Vriens et al., 2016).

This form of accountability has some advantages. The narrative form of accountability provides contextualization, what the calculative form misses. Narrative accountability can interpret, invent, or make up the figures (Kamuf, 2007). "Numbers do not narrate, interpret,

invent, or make up the figures" (p.252). Another advantage of narrative accountability is that is provides the possibility to have some form of a dialogue. O'Neill (2002) argues that communication between professionals is possible through this form of accountability and that this is positive for the professionals. Being able to explain things between professionals and others, increases the creating of trust.

However, this form of accountability also has some disadvantages. This form of accounting has almost no chance of making the intention understood given the inertia of habitual usage (Kamuf, 2007). "Narrative accounting and computational account are even former occupying to stand in rough opposition to each other, the former occupying a plea in the vicinity of an act of witnessing or testimony, called, very loosely, subjective, while the latter lies at or close to the pole of what counts as objective fact, evidence, or even proof." (p.252). Additionally, it is an insufficient form of public professional accountability because for outsiders other than the professionals it is difficult to understand the complicated information (Vriens et al., 2016). Vriens et al. (2016, p.1-2) argue that the narrative form may be less 'distorted' than the calculative approach.

Here, the dilemma of professional accountability arises (Vriens et al., 2016). On the one hand we need some form of accountability so that trust in professionals is warranted, but on the other hand are the current forms of accountability insufficient (Vriens et al, 2016). O'Neill (2014) argues that we need some kind of intelligent form of accountability because there is no reason to assume that the current forms of accountability can replace trust. "Unless at some point in places in some claims or some persons, institutions, or processes, there will be no reason to place it in any procedures for securing accountability" (p.177). O'Neill (2014) states that this intelligent form of accountability should support the intelligent placing of trust. It should focus on judging others' trustworthiness in the relevant matters. Roberts (2009) also emphasis this idea of looking for more intelligent forms of accountability. We cannot manage without transparency, but "we cannot manage only with transparency – out instinct to invest in yet more transparency as the only remedy for the failures of transparency – but rather should see transparency as at best of supplement to more context specific intelligent accountability" (p.968).

2.2.3 Conditional accountability

Vriens et al. (2016) propose a third way of accountability that can circumvent the dilemma of professional accountability. This approach focuses on the conditions enabling professional

conduct and its results. “This entails, for instance, showing that professionals have the time, tools, regulatory potential, information, or incentives, to actually and properly apply their specific knowledge and experience and dedicate themselves to realizing some societal value” (Vriens et al., 2016, p.3).

Vriens et al. (2016) state that professional work is always carried out in a particular social context – which conditions professional work. Vriens et al. (2016) state that is makes sense to incorporate these conditions in professional accountability. Vriens et al. (2016) identify two general influencing conditions based on different authors, namely the goals and the infrastructural arrangement.

By the goals of conditional professional work, Vriens et al. (2016, p.6) explain: “They determine what to pay attention to while carrying out processes, and hence, they have an influence on how the transformation processes are carried out.” Vriens et al. (2016) argue that market and bureaucratic goals could hinder the professional work in two ways. First they could “hinder the application and further development of specialized professional knowledge” (Vriens et al., 2016, p.7. Secondly, they could “hinder professional work as intensive technology”. And finally, “the more market and bureaucratic goals enter the profession, the less work is conditioned as ideal-type professional work” (Vriens et al., 2016, p.7).

The second dimension described by Vriens et al. (2016) is about the infrastructural arrangement. According to Vriens et al. (2016), these arrangement consist of three aspects that directly could influence the way professionals carry out their work:

1. **Structure:** “The way in which professional work is structured, how it is broken down into sub-processes and how it is coordinated” (Vriens et al., 2016, p.6). Traditionally, structure is made up of the degree of formalization/standardization, specialization, and centralization (Vriens et al., 2016). Structures of tasks cover the complete ‘job-to-be-done’, with decentralized regulatory potential and with low degree of formalization, fit better the ideal-type of professional work.
2. **Performance management systems:** Used to select, assess, appraise, monitor, reward, sanction, motivate, and develop professionals and their performance (Vriens et al., 2016). These systems have two purposes. Firstly, they translate goals into targets for individual work. Secondly, they are related to monitoring whether professionals reach the goals set and to account for them (Vriens et al., 2016). Vriens et al. (2016) refer to three issues concerning performance management systems: “(1) the degree to

which ideal-type professional goals enter these practices, (2) the degree to which professionals themselves take part in these practices, and (3) the form of these practices."

3. **Technological conditions:** A large set of means, including the equipment they use, the physical lay-out of the space they work in, the ICT, etc. (Vriens et al., 2016). Vriens et al. (2016, p.1186) state that "without the proper equipment, ICT, etc., professionals will have a hard time reaching their goals".

Just like with the calculative and narrative form of accountability, conditional accountability has advantages. With calculative accountability, one is worried about professional work meeting certain targets or if it is carried out according to some set of rules or procedures. And narrative accountability allows for explaining and discussing reasons for particular behaviour (Vriens et al., 2016). These two forms of accountability both focus on professional conduct itself. According to Vriens et al. (2016) conditional accountability entails showing the degree to which goals are set for professionals and the infrastructural arrangements in which they work. These infrastructural arrangements enable three aspects. First, they enable the application and further development of professional knowledge. Second, they enable the security of professionals work as intensive technology. This means that they enable context-specific diagnosis and treatment based on discretion and feedback. Finally, they make sure that professionals are/keep on being dedicated to the societal value of the profession they belong to (Vriens et al., 2016).

This form of accountability also has some disadvantages. Vriens et al. (2016) explain some objectives in their article. The first objective Vriens et al. (2016) describe is the fact that the conditions do not guarantee ideal-type professional conduct. Despite the fact that someone meets the conditions that are set, there are still professionals who perform poorly or show opportunistic or downright criminal behaviour. The second objective is that good calculative indicators make accounting for conditions redundant (Vriens et al., 2016). When the indicators are met, but the conditions for professional conduct were not in place, one might have reasons to be suspicious about these indicators and their values (Vriens et al., 2016). But such calculative indicators are difficult to obtain. Another objective argued by Vriens et al. (2016) is that accounting for conditions denies that economic and bureaucratic control goals are relevant for professional conduct. Especially economically, uniformity and equity are goals that seem irrelevant when accounting for conditions. So, it could be argued that accounting for conditions does not balance all relevant goals (Vriens et al., 2016). The final

objective that is stated by Vriens et al. (2016) is the objective that if accounting for conditions means that there is no longer a place for calculative and narrative accountability, then it is no good. Vriens et al. (2016) argue that the conditional approach of accountability is an intelligent form and can help to regain trust, but they do not say that calculative and narrative forms of accountability are no longer relevant. "Rules, regulations, or protocols are still important for professional work but only if they are accepted as professionally useful and if, based on discretionary professional judgment, deviations are possible (Vriens et al., 2016, p.16). Vriens et al. (2016, p.16) believe that "accounting for conditions may have a place in professional public accountability, alongside calculative and narrative accountability, and that it may help to foster public trust."

2.2.4 Summary of the three forms

In the previous chapter (§2.2.1, §2.2.2, §2.2.3), the three different forms of accountability were elaborated. All the different forms have certain advantages and disadvantages. For this research it is important to get a clear understanding of the different advantages and disadvantages of the three different forms. In order to get this clear view on the different forms, a summary was created in the form of a table. Table 1 will show the summary of the three different forms of accountability.

	Calculative accountability	**Narrative accountability**	**Conditional accountability**
Description Vriens et al., 2016	Account in terms of following procedures and rules, or working to pre-determined targets and standards	Account in the form of explaining to and discussing with others reasons for conduct	Account in the form of conditions (goals/infrastructural arrangements) enabling professional conduct and its results
Focus on the relation between Vriens et al. (2016)	Organization to government	Professional to patient	Working environment to professional
Scale (audience)	Distant others (management, public)	Those in proximity (direct clients; other professionals)	Possible for both distant others and those in proximity
Object of account Vriens et al., 2016	Professional conduct and/or results	Professional conduct and/or results	Conditions for professional conduct
Advantages	● Simplicity of scores on performance indicators makes them easily agreeable into rankings and league tables ● Transparent and open	● Provides contextualization (Kamuf, 2007) ● Can interpret, invent, or make up the figures (Kamuf, 2007)	● Showing the degree to which goals set for professionals ● Enable the application and further development of professional knowledge

	● Can secure accountability to wider publics ● Demonstrate the fairness of resource allocation and other decisions O'Neill (2014)	● Possibility to have some form of a dialogue (Kamuf, 2007) ● Communication possible what increases trust (O'Neill, 2014)	● Enabling context-specific diagnosis and treatment based on discretion and feedback ● Professionals are/keep on being dedicated to the societal value the profession belongs to Vriens et al. (2016)
Disadvantages	● Decontextualization; Accounting something that abstracts from the specific situations professionals have to respond to (Vriens et al., 2016) ● Performance indicators provide simplistic and misleading proxies (O'Neill, 2014) ● Potential of creating perverse incentives (Møller, 2009) ● Instrumentalism may lead to poor professional performance (Møller, 2009)	● Inertia of habitual language; almost no chance of making the intention understood (Kamuf, 2007) ● Insufficient form of public professional accountability because difficult to understand the complicated information for outsiders (Vriens et al., 2016)	● Conditions do not guarantee ideal-type professional conduct ● If calculative indicators are met, we do not need to account for the conditions that led up to these results ● It downplays other goals (efficiency, profitability, uniformity and equity) Vriens et al. (2016)

Table 1: Summary of the three different forms (Kamuf, 2007; Møller, 2009; O'Neill, 2014; Vriens et al., 2016)

The three different forms of accountability have their own advantages and disadvantages. The question that is raised here is how doctor perceive the impact by the three different forms of accountability on their tasks? To explore this, this study focusses on the profession of doctors, and particular doctors who work in hospitals. In order to explore this, accountability in health care is elaborated in the next paragraph.

2.3 Accountability in hospitals

The aim of this research is to study how doctors perceive the impact of the three different forms of accountability on their tasks. The three different forms of accountability and their advantages and disadvantages are explained (§2.2.1, §2.2.2, §2.2.3), so now accountability in hospitals will be discussed in terms of levels of accountability according to the KNMG (Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunde; Royal Dutch Society for the furtherance of Medicine) Manifest (2007). In sub chapter §2.5 the different groups of tasks are discussed that will be used for the conceptual model of this research (§2.6). The tasks come from two different articles by Ampt, Kearney, Rob and Westbrook

(2008) and Zimmer (2017). Both the articles discuss the doctor's work distribution in hospitals. Before discussing the tasks of doctors within hospitals, the levels of accountability in hospitals will be explained. The KNMG manifest (2007) states that a doctor must be accountable on four different levels. For this study, the focus is on two levels, patient and professional group. Because of time restrictions and research on the importance of the levels, the other two levels are less relevant for this study.

2.3.1 Patient level

"Making healthcare transparent in the current quality policy" is the central goal of accountability (KNMG, 2007, p.8). To be able to give adequate accountability, the physician is expected to systematically organize the quality of their work. It goes without saying that the doctor is accountable for his/her medical actions; "Together with the patient, the doctor explores the request for help, what the diagnostic process is, explains which diagnosis he/she has made and what the treatment proposal is (including the risks and the pros and cons)" (KNMG, 2007, p.8). A professional standard is also included in the KNMG (2007). This describes the standards of professional conduct and consists of a set of rules of conduct, standards, guidelines and protocols. In principle, a medical specialist must always apply this, unless it is necessary to deviate (KNMG, 2007, p.4). If this is the case, then a medical specialist must be able to justify his or her decision. The professional standard is not fixed and the medical profession determines the primary interpretation itself (KNMG, 2013).

2.3.2 Professional Group level

The second level is the professional group. This is done on the basis of peer evaluation, which is based on a consensus on medical professional practice and applicable guidelines. A doctor must also, if necessary, call colleagues who are acting incorrectly to account. The purpose of this is to make it easier to talk to a colleague about his/her functioning and to prevent it being "too late".

2.4 Tasks of doctors within hospitals

This paragraph discusses the different tasks of doctors within the two levels of accountability in hospitals. These tasks are based on two articles by Ampt, Kearney, Rob and Westbrook (2008) and Zimmer (2017) who both wrote an article on the work distribution of doctors within hospitals, and on personal communication with three doctors from the Albert Schweitzer Hospital in Dordrecht.

There are many different types of medical professionals with different types of tasks. This is because within a hospital, almost every doctor is specialized in a certain segment of medicine. Think of pulmonologists, radiologists, surgeons, and so on. Every doctor performs his / her own tasks and like was said before, these can differ. But ultimately a similarity can be found in those different tasks per specialism. Because despite the fact that each specialism a patient different examines, it can all be put under one concept, namely make a diagnosis. Ampt et al. (2008) and Zimmer (2017) both did a research on the work distribution of doctors within hospital and created an overview with tasks and the associated definition. For this research, a selection of the tasks described by Ampt et al. (2008) and Zimmer (2017) was made who are related to the two levels of accountability in hospitals. Some of the tasks are left out because they are not of value for this research, like taking a lunchbreak.

2.4.1 Direct patient care

Ampt et al. (2008) define direct patient care as "all tasks directly related to patient care, including direct communication with patient or family or both. It does not matter which specialism a doctor has in the hospital, every doctor is in direct contact with patients" (personal communication, May 20, 2019). This consists of patient meetings of which he/she has almost 52 a week (personal communication, May 20, 2019).

2.4.2 Indirect patient care

Indirect patient care are all the activities on behalf of particular inpatients without their presence, like documentation (Zimmer, 2017). Ampt et al. (2008) give examples like searching for a patient's medical record, reviewing results, planning care, etc. Personal communication (May 20, 2019) describes this as the assessment of x-rays.

2.4.3 Documentation

Documentation means any recordings of patient information on paper or computer, excluding medication documentation. Documentation can be linked to both the two levels of accountability. Ampt et al. (2008) make a distinction in discharging summaries and other documentation. With discharging summaries is meant specific documenting discharging summaries using an electronic discharge summary system (Ampt et al., 2008). These summaries are meant for both the patients and the professional communication. Personal communication (May 20, 2019) states that almost three quarters of the time is lost on preparing reports after patient meetings or assessing x-rays.

2.4.4 Professional communication

Zimmer (2017) also describes this as 'general inpatient activities', which means activities not on behalf of particular inpatients but connected with the delivery of care in general, like meetings, team discussions, etc. Ampt et al. (2008, p.507) further elaborate this definition by saying: "All communication with another health professional not related to medication, including meetings, requests for medical consultation and discussion about planning care." Personal communication (May 20, 2019), states that personal communication consists of meetings with the commission, department meetings, product group meetings, performance reviews within the department, and other communication with professionals about patients or treatments.

2.5 Conceptual model

As is described in the theoretical framework, a doctor has to account on two different levels stated by the KNMG manifest of medical professionality (2007); the patient level and professional group level. These two levels consist of many different tasks that can be divided into four subtasks: direct patient care, indirect patient care, documentation and professional communication. Doctors are obligated to give account for these different tasks. As also is discussed in the theoretical framework, at this moment there are three different forms of accountability; the calculative, narrative and conditional approach (Vriens et al., 2016). Each form of accountability has its own advantages and disadvantages.

The conceptual model is based on the literature above (§2.2, §2.3, §2.4). The aim of the research is to study how doctors perceive the impact of the three different forms of accountability on their tasks. On the left of the conceptual model, the three different forms of accountability are shown. The three forms have their own advantages and disadvantages. There for they have a possible impact on the tasks of the professionals on four levels of accountability in hospitals, which can be found on the right.

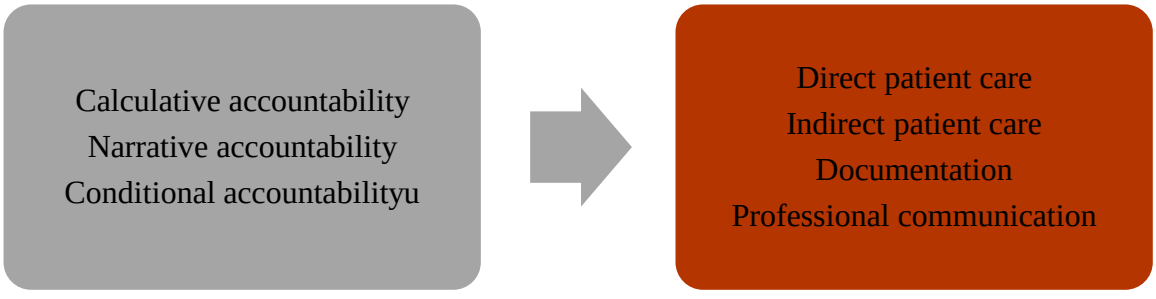

Figure 1: Conceptual model of accountability and tasks from a doctor

What we do not yet know is what the impact is of the three forms of accountability on the tasks of the professional (in this study: doctors within hospitals). To be able to answer the research question, it is important to explain these different tasks in regard to the different forms of accountability. To get a clear understanding, the different levels of tasks of doctors within hospitals are related to the different levels of accountability by the KNMG. Based on this, it can be investigated what the impact of the forms of accountability is, looking at the advantages and disadvantages, on the tasks and duties of doctors. Finally, a conclusion can be drawn from the different perspectives on accountability for the various tasks of doctors.

3. Methodology

In this chapter is indicated which method will be applied for this research. First, the used method is elaborated (§3.1). In the next paragraph the overall research design is elaborated in terms of sample and data sources. In paragraph 3.3 the data analysis is elaborated and finally, the limitations of the research are elaborated and how research ethics are addressed (§3.4).

3.1 Research design

The main objective of this research is to contribute to the understanding of how the different forms of accountability effect different tasks that are executed by doctors in hospitals. For that reason, a *qualitative approach* is used for this research. According to Bleijenbergh (2013) a qualitative approach makes it possible for the respondents – the doctors in this case – to give more information about the perspectives of different parties. "Qualitative research concerns all forms of research aimed at collecting and interpreting linguistic material to make statements about a (social) phenomenon in the reality" (Bleijenbergh, 2015, p.12). In contrast, quantitative research is useful when you want to investigate whether something is occurring or not. In order to answer the research question, in-depth research of the phenomenon is necessary and quantitative research is unable to do this and qualitative research aims to describe the behaviour, experiences and 'products' of those involved (Boeije, 2009). Qualitative research has an open-ended character what is key in this research. This open-ended character makes it possible to draw rigid relations, because each doctor has his/hers own perceptions on the different perspectives mentioned in this research.

In order to gain the needed information to give answer to the research question, an *abductive approach* is used. This approach is a combination of an inductive and deductive approach, and will lead to the generation of new ideas. Unlike with the inductive approach, with deductive research there is already prior information and ideas on the subject (Vennix, 2001). Regarding the duties of doctors and accountability, it is already clear in some way how doctors are accountable. At this moment, doctors are accountable on four different levels: patient, professional group, institution and the society. The tasks of doctors are related to these four levels. An overview can be found in Table 4 to get a clear image how doctors have to account on the four different levels stated by KNMG (2007) and the three different forms of accountability stated by Vriens et al. (2016). As stated above, each doctor has his/hers own perceptions and all the information is valuable to the research and contributes to the

completeness. These new ideas determine which form of accountability, described by Vriens et al. (2016), impacts most a certain task based on the perspectives and ideas of the doctors themselves. The advantages of the inductive approach, is that new concepts can be found that are not yet known. The ability to ask open and follow up question clarify the meanings and ideas on accountability of the doctors. This is not possible when you only use the deductive approach, and that is why there is chosen to use the abductive approach.

In order to collect the data for this research, a target population is identified. Vriens et al. (2016) state that professionals themselves are the most informed when it comes to judging their own working activities. Also, in order to investigate how the different forms of accountability have an impact on the tasks of doctors it is clear that the professionals themselves (doctors) are the target population. The sampling method that is used in this is research is *convenience sampling*. The respondents are selected based on availability and willingness to take part. Through the personal network and messages send on platforms like LinkedIn, the list of respondents was created. An overview of the respondents is shown below.

Specialism	Hospital
1. Pulmonologist	Albert Schweitzer Hospital
2. Team leader lung department	Zuyderland Medical Center
3. Radiologist	CWZ
4. Trauma surgeon	Radboud Medical Centre
5. Urologist	CWZ
6. Neurosurgeon	Radboud Medical Centre
7. Oncologist and HR advisor	CWZ

Table 2: Overview of interview respondents and hospitals

As can been seen in Table 2, for this research, doctors in different hospitals are interviewed. This is chosen because doctors within hospitals have to account for everything they do. There is pressure from different parties, like the society, government, and the hospital itself to make the practice and results of doctors transparent. Also, there has not been done any empirical

research on what the impact is of the three different forms of accountability on the duties of doctors. These two arguments make it very interesting to investigate the study within different hospitals.

3.2 Semi-structured interviews

Interviews are an appropriate method to gain the needed information and knowledge. By means of interviews, an attempt is made to map the opinions and experiences of the doctors within hospitals with regard to accountability for various tasks. The interviews are *semi-structured*. In semi-structured interviews, the questions asked are prepared and guided by identified themes in a consistent and systematic manner (Dumay & Qu, 2011). Between the questions there are probes designed in order to elicit more elaborate responses. This ensures that there is room to respond to given answers and that depth is created in the results. In order to perform the semi-structured interviews, an interview guide is created. “The semi-structured interview is defined by the interviewer working from a guide in which the themes and a number of key issues are defined in advance” (Justesen & Mik-Meyer, 2012, p.53). Table 1 (§2.2.4) in combination with the conceptual model (Figure 1) as developed in §2.5, are used as guideline for the interview guide. The interview guide is shown in Appendix 1 and Appendix 2. In order to answer the research question, questions are asked regarding the tasks of doctors on the four different levels and their relationship to accountability. To investigate which form of accountability impacts most the tasks of doctors, questions are asked regarding positive, negative and improving aspects of accountability on their tasks. An exemplary interview question is “To what extent do you think that the way of accounting when it comes to direct patient could be improved?”. This question covers the conceptual model and leaves room for different interpretations.

During the interviews, questions are changed and follow up questions are asked. In order to answer the research questions and realize the objectives, this form of interview fits best this research because it can cover the content of the research; investigating which form of accountability has the most impact on the tasks of doctors within hospitals. In order to secure the anonymity of the respondents, personal data is not named in this research. As a documentation method, audio recording is chosen as the most suitable method. The consent of the respondents is requested prior to the interviews in order to meet the requirements of this method (Justeses & Mik-Meyer, 2012). The interviews are transcribed afterwards and shared with the respondents.

3.3 Data analysis

This research aims at exploring human experience through data, collected in interviews and literature. Three common methods of analysing the data that is gained from the interviews are open coding, axial coding and selective coding (Boeije, 2005). The first step in this coding process is 'open coding'. Here the researcher starts with the data and creates codes from this data. After the interviews are held, the open codes can be created through the answers given by the professionals. The next step is axial coding. With axial coding the researcher starts with the created codes from the theory and afterwards looks at the data. Theory that is used in this research are the three different forms of accountability stated by Vriens et al. (2016) and the four different subtasks of accountability by the KNMG manifest (2007). The main aim of axial coding is that the meaning of the important concepts are discovered and with the open codes, examples could be provided to explain these concepts. Also, if necessary, new codes could be created. The last step of the coding process is selective coding. In this step, the core categories are further refined and core categories are developed. Systematically, these categories are related to all the other categories. In Figure 2, a model is shown of the coding process.

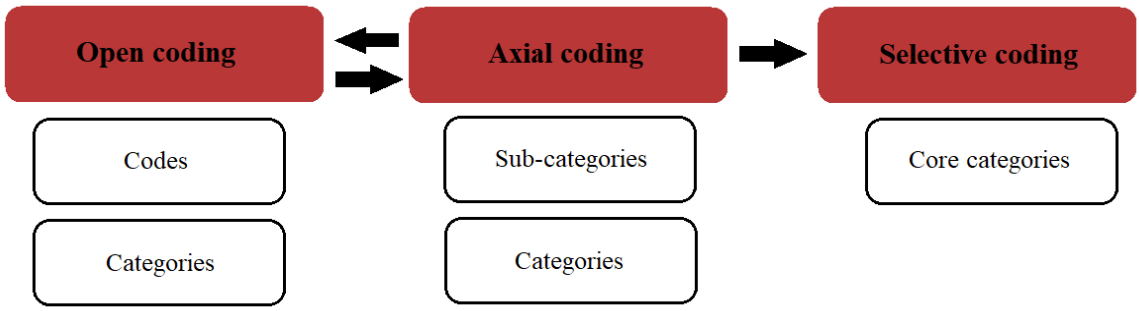

Figure 2: Coding process (Boeije, 2005)

In this research, the above coding process is used to analyse the transcripts. As is described above, the open codes are created through the answers given by the professionals. In the next step with axial coding, the researcher starts with the created codes from literature and afterwards looks at the data. These codes mainly came from the literature used in Chapter 2 of this research. Codes used are related to the three forms of accountability and the levels of tasks from doctors. In addition to the codes related to the literature, codes are developed that, according to the researcher, are important for this research. Table 3 below shows an example of how the coding process is applied in this research. A number of quotes from the transcripts are used for this overview as an example.

Open Coding			Axial coding		Selective coding	
Quote		Code	Sub-Category		Paradigm Element	Category
"The moment you do it differently, you can do that in general, as long as you have documented why" (R.1, line 201-202)	→	Deviate when documented	Possibility to deviate from guidelines and protocols	→	Causal conditions	Consequence calculative accountability
They are guidelines, protocols and argued you may deviate from them. (R.5, line 98-99)	→	Argued you may deviate	→		→	
If you want something, you have to be able to explain it and it is also determined what the consequences are for costs or personnel. (R. 3, line 231-232)	→	Being able to explain when you want something				
We are responsible for our own actions, so we must be able to justify that we run it through the protocol. (R.2, line 55-56)	→	Run it through the protocol	→	Take guidelines and protocols into account		
Of course you can deviate from protocols and rules. You have certain safety conditions, timeouts, checklists and things like that. (R.6, line 80-81)	→	You have certain rules				

Table 3: Overview coding process

3.4 Research limitations and ethics

In this research, it is very important that the participants are treated with respect. A number of things must be taken into account. First, the participants must voluntarily want to participate in the research and must be able to step out of the research at any time if they wish. Second, it is important that information regarding the research is openly shared with the participants. Prior to the interviews, information about the goals of the research must be shared and information about the processing of information must be shared during the conduct of the

research .This prevents participants being able to criticize the departed information at the end and there is the possibility to consult during the research. In addition, prior to the interviews, permission will be requested from the participants to record the interviews. In order to secure the anonymity of the participants, transcripts of the interviews are edited. By this, also the confidentiality of the information is secured. The transcripts will be kept safely and will not be used for other purposes rather than the research. In addition to openly share the information, after the interviews the participants will be sent an overview of the results as well as a copy of the final research paper.

A possible limitation of this research could be that a sample bias or "volunteer bias" occurs. Because convenience sampling is used, the chance occurs that the respondents who volunteered may be different from those who choose not to. Because of this, limited access to information can occur. For example, doctors cannot be completely honest about their accountability findings because they are afraid that they will harm organizational values, or they cannot give all the information based on the patient privacy.

Another limitation is that it is not possible to interview all doctors within the hospital. As a result, the results of the study cannot be fully generalized among all doctors in the Netherlands.

In this research, only four out of the six levels that are stated by the KNMG manifest (2007) are used. This is chosen due to the lack of time and because personal communication has shown that the other two levels (institution and society) have little to do with the accountability that doctors face every day. This can cause a limitation in the research because useful information regarding accountability on these two levels is not disclosed.

4. Interview analysis

In this chapter, the data found through interviews will be presented. This data will be compared with the information found in the theoretical framework with the aim of answering the main question of this study: *"How do doctors perceive the impact of the three different forms of accountability on their tasks and duties?"* This research is of usefulness for the knowledge gap on the role of the different forms of accountability in relation to tasks in a specific profession and it will give insights in how doctors perceive the impact of the three forms on their tasks. In order to answer the research question, the inductive way is used by asking questions to stimulate the medical specialist to form their own perception of the different concepts. The analysis is based on a number of sub sections. In the first section (§4.1) the direct patient care in relation to the three different forms of accountability will be discussed. The second section (§4.2) will discuss the relation between the indirect patient care and the three different forms of accountability. In the third section (§4.3) the professional communication will be discussed. This will also be done in relation to the three different forms of accountability. In the analysis, for each relationship between task group and form of accountability, the occurring effects that are experienced by the respondents will be discussed. In the theoretical framework (chapter 2) and the method (chapter 3), four task groups are discussed (direct patient care, indirect patient care, documentation and professional communication). The results concerning documentation overlap with both direct and indirect patient care. That is why the choice is made to distribute the documentation between these two task groups. The relationship between documentation with the three different forms of accountability and its effects will therefore be divided among these two sections (§4.1 and §4.2). Finally, in the last section (§4.4), a bridge will be made between the effects of the three task groups in relation to the different forms of accountability.

4.1 Direct Patient Care

Ampt, Kearney, Rob and Westbrook (2008, p.507) describe the direct patient care as "all tasks directly related to patient care, including direct communication with patient or family or both". The respondents see the outpatient conversations and the interventions done as the most important tasks within direct patient care. All doctors spend about two whole days spread over the week on outpatient clinics. Here patients come who have already been treated or who still need to be treated. In these conversations, diagnoses, treatments, alternatives, etc. are discussed with the patient.

4.1.1 Calculative accountability

In the theoretical framework (§2.2) it becomes clear that calculative accountability is giving account in terms of following procedures and rules, or working to predetermined targets and standards (Vriens et al., 2016). Within direct patient care, calculative accountability plays a role in terms of the production figures that are set for the different medical teams within hospitals, and guidelines and protocols concerning interventions and documentation.

These production figures apply both to the outpatient conversations and to the interventions that are carried out. For example, this means that a department or team must see a certain number of patients in a certain time. Because of this, the outpatient conversations have an average duration. As is indicated by the respondents, an outpatient conversation has an average duration of about fifteen minutes. The set outpatient times are set up in this way so that the set production quantity can be achieved. In this sense, doctors are accountable for achieving the stated production quantity. Despite the stated production quantity, the respondents do not feel like they have to give account to the patient. Because of this it is important to understand what doctors understand by 'accountability'. The respondents describe accountability as providing good care to the patient (R1, R2, R4, R5, R6, R7). This concept of good care emerges in all the interviews as the most important value for doctors. "*I always believe that the patient must be well informed. First, in terms of examinations, what the intention is and what the risks are. In terms of the treatment plan I naturally also want to explain what the expectations are, what possible side effects are. Sometimes, very often, also the alternatives. That you say you can do that treatment, or that, or maybe you have to wait.* "(Respondent 3).

An effect arises on the providing of good care because of calculative accountability with regard to the outpatient conversations. Because of the set outpatient times, in order to achieve the stated production quantity, some of the respondents experience too little time for the patients. "*I do experience that I often have too little time for the patient. With us, an outpatient conversation is 20 minutes long, but yes, there are patients among them who have ten injuries and that would mean that I would have to run the entire patient through with 2 minutes per injury. And then you have to tell about it, keep things apart, investigate, give advice about it or propose a treatment. So that often doesn't work at all."* (Respondent 3). Like van Heijst (2011) discusses, doctors nowadays have less and less time to provide good care. Van Heijst (2011) states that the actions of medical specialists increasingly serve different purposes than providing care. The respondents always take the time they need for a

patient, in order to provide the care that the patient deserves. This causes delay with the outpatient conversations. The quote stated above shows that every patient is different and that the set outpatient time cannot be set for every patient.

Another effect that arises due to calculative accountability in regard to direct patient care is decontextualization. Two of the benefits of the calculative form of accountability are that it is transparent and open, and it can secure accountability to wider publics (O'Neill 2014). Respondents confirm this in terms that the production quantity is an easy number to bring out to instances and society. On the other hand, the respondents have difficulty with the way accountability is given. One of the disadvantages of the calculative form of accountability is that decontextualization arises (Vriens et al. 2016). It stands for that doctors account for something that is abstract from the specific situation in which they have to respond to (Vriens et al., 2016). The statement of van Heijst (2011) about that the actions of medical specialists increasingly serve different purposes than providing care, is also applicable to this concept of decontextualization. In this sense, transparency and decontextualization are directly opposite of each other. On the one hand, the work of doctors becomes more transparent due to the production figures, but on the other hand it does not show what the doctors have to deal with in reality. *"Well the question is, you are judged on indicators and parameters that are not necessarily good care. It is a derivative of it. Because, what is easier than just counting knots, how many interventions have you done? If you can be judged on that for the level of quality it would be pretty simple, but that is not only determined by how many interventions you do. That depends on all facets around it, but no measure or appreciation is given to that and that is of course difficult."* (Respondent 6). The above quote confirms another disadvantage of the calculative form of accountability that is connected to the disadvantage of decontextualization. It provides simplistic and misleading proxies (O'Neill, 2014). The respondents state that the figures do not show the actual situation that the doctors are in, because the figures do not expose what is happening "behind the door" (R2, R4, R5, R6, R7). One of the respondents state that because of the decontextualization in regard to production figures, he/she feels not appreciated. An effect of this could be that poor professional performance arises, another disadvantage of calculative accountability stated in literature (Møller, 2009). Because such instrumentalism may lead to poor professional performance if the good thing to do in a specific situation no longer depends on context-specific discretionary professional judgement and dedication, but only on what the rules prescribe or on the targets that need to be reached (O'Neill 2002, 2014; Schwartz 2011 as

cited in Vriens et al., 2016). The respondents do not have the feeling that they suffer by poor professional performance due to decontextualization. The respondents state that they have chosen this profession for a reason and the most important thing in their work is providing good care (R1, R3, R6, R7).

As is stated in the introduction of this chapter, documentation is no longer a separate task group but it is divided among direct patient care and indirect patient care. Documentation stands for everything with regard to any recordings of patient information on paper or computer. One important example of this would be the patient file that every doctor needs to forge when they treat or speak to a patient. This patient file is an online document where doctors can summarize their findings, treatments, medicines, etc. When it comes to calculative accountability, the set outpatient time for the achievement of the production quantity is of influence on the working hours of the doctors. The processing of the outpatient conversations into the patient files takes a long time (R1, R3, R4, R5, R7). Contrary to some years ago, where the processing was done with pen and paper, doctors nowadays process the conversations digitally. There is some deviation between the different perspectives of the respondents when it comes to the effect of documentation on the working hours. On the one hand the respondents state that it is "part of the job" (R2, R3, R6), but on the other hand some respondents state that too many actions and choices need to be documented what takes much time (R1, R4, R5, R7). *"In practice, it is actually impossible to update the outpatient conversation yourself, administratively. At least maybe it is possible, but then you really have to constantly look at the screen and then I feel like the patient has not the idea that he has received the attention he deserves. So I don't do that and it means that I will still have to update the clinic administratively after the outpatient visits."* (Respondent 1). The quote shows that Respondent 1 has chosen to process his/hers outpatient conversation after the outpatient visits. That automatically means that this effects the working hours of the doctors, because it has to be done after or next to the general tasks a doctor has. A consequence of the effect on the working hour is that it could affect the way of working. Respondent 1, for example, states that it feels like inferior to what a doctor should do because documentation has little to do with making people better. In relation to the disadvantages of the calculative form of accountability, this could be addressed as the possibility of poor professional performance. On the other hand, despite the fact that documentation bothers doctors when it comes down to mandatory tasks, the respondents do not feel like they experience too much

pressure because of the documentation that could lead to poor professional performance (R1, R3, R4, R5).

In addition to the patient file, doctors also have to account to external instances that expect or demand certain figures when it comes to the work of medical specialists. These external instances could be general practitioners or health insurances. For example, despite the fact that the patient's report can be written digitally and patients can now look into their online files themselves, letters still have to be made separately for general practitioners (Respondent 1). When it comes to health insurances, they expect production figures. "*Every year you have the requests from the care institute, the inspection and the health insurers. They can request everything and we deliver it all again. You are also judged by it, while I think it is often not a very good measure of what we actually do. And that is the frustration."* (Respondent 6). This quote confirms the earlier analysed effect of decontextualization. The production figures that are delivered to the different external instances do not represent the real performed work of doctors. In addition to this disadvantage, and maybe even more disturbing for doctors, is that heath insurances judge hospitals and medical teams on the basis of these figures (Respondent 6). The biggest frustration here, according to Respondent 6, lies in the fact that these external instances do not have the medical knowledge that doctors have and by that cannot understand things in the way that medical specialist do. "*There are many more external standards that you have to meet and if you then have to describe something as stressful, it would be that. That sometimes means that you suddenly have to stop doing things like you have done for years because the standards have changed."* (Respondent 6). On the one hand someone with less knowledge about medicine has the power to change things, but on the other hand it cannot be overcome because hospitals or healthcare itself do nothing about it. "*It is not about quality, it is only about the health insurer that shows that they are doing something about quality. It is a kind of chess game let me say."* (Respondent 6).

To summarize, the effect of calculative accountability on the core tasks of direct patient care (outpatient conversations and the interventions done) is at first putting patients in the same framework, when it comes down to the set outpatient times, has a negative effect on the providing of good care. With this framework is meant that every patient gets the same outpatient time no matter how old or how complicated their diagnoses is. The two above described core tasks are combined in this concept according to the perspective of the respondents. Next, the shift in the intention of care (decontexualization) has a negative effect on the perspective on accountability according to doctors, but has no direct negative or

positive effect on the tasks. Finally, documentation has a negative effect on the core tasks of doctors because it feels inferior to the providing of good care and it takes much time that better could be invested into the patients. In the next paragraph, the narrative accountability in regard to the direct patient care will be analysed.

4.1.2 Narrative accountability

Vriens et al. (2016) explain narrative accountability as giving account in the form of explaining to and discussing with others reasons for conduct in a way that allow for freedom. In direct patient care, narrative accountability plays a role in the outpatient conversations. Here, for example, the doctor explains a diagnosis to a patient, discusses several alternative treatments, listens to possible objections, and arrives professional preference (Vriens et al., 2016).

O'Neill (2002) states that one of the advantages of the narrative form of accountability is that there is the possibility to have some form of dialogue and that this increases trust. In comparison with a few years ago, the medical specialist had more autonomy. In outpatient conversations, the diagnosis and treatment plan of the doctor was the right thing to do. Nowadays, patients are more articulate and want to be involved in the decision making process. Respondents state that patients have always had this right of shared decision making, but the autonomy of the doctor was too high. Respondent 5 states that since a few years, trust has become a big issue in not only healthcare, but everywhere. *"Even when we buy a closet, we want to be absolutely sure that everything is okay."* (Respondent 5). Because of all the information available on the internet, people become more assertive (R1, R3, R4, R5, R6, R7). An effect that arises because of the more assertiveness of patients is that doctors have to explain more, because there will be more discussed in outpatient conversations. Doctors find this very pleasant (R1, R3, R6, R7).

Despite the fact that the respondents find the possibility to have a dialogue and discussion with the patients as pleasant, it sometimes occurs that patients do not fully understand what is discussed. One of the disadvantages of the narrative form is that it is an insufficient form of public professional accountability because it is difficult to understand the complicated information for outsiders (Vriens et al., 2016). Despite the fact that Vriens et al. (2016) focus on external instances with this statement, it certainly also applies on patients themselves. In relation to the stated outpatient times (calculative accountability), doctors sometimes have to explain and discuss difficult diagnoses or treatments. "*And nowadays it is*

of course true that we all want to let the patient participate in the decision-making process, but you can only let the patient participate in the decision-making process if the patient has really good information. And that is of course difficult, because the patient is not medically qualified in general and they can function at a very different level in terms of intelligence." (Respondent 5).

The last effect that arises is already discussed in the paragraph that shows the effect of calculative accountability on direct patient care about the influence of external instances on the work of doctors in regard to documentation. One of the disadvantages of the narrative form of accountability that is already discussed above, is that it is an insufficient form of public professional accountability because it is difficult to understand the complicated information for outsiders (Vriens et al., 2016). This is related to external instances that doctors have to deal with. As was stated in the previous paragraph, the frustration is that someone with less knowledge about medicine has the power to change things. From the analyses it stays unclear to what extent the medical specialist has some form of dialogue with external instances. By that, the disadvantage of narrative accountability also relates to calculative accountability in some forms.

Narrative accountability only has effects on one core task of direct patient care, outpatient conversations. In summary, narrative accountability first has a positive effect on the possibility to have a dialogue with patients because patients nowadays have more information due to the internet. Despite the positive effect, in combination with the negative effect of calculative accountability about the set outpatient times, narrative accountability has a negative effect on the level of understanding for some patients.

4.1.3 Conditional accountability

The conditional form of accountability is a developed approach that focuses on the conditions enabling professional conduct and its results. Vriens et al. (2016) give examples like showing that professionals have the time, tools, regulatory potential, information, or incentives, to actually and properly apply their specific knowledge and experience and dedicate themselves to realizing some societal value. With the calculative and narrative form of accountability, there is being account for the professional work itself. With conditional accountability, there is being account for the conditions for professional work. This means showing that the conditions enabling ideal-type of professional conduct are realized. As was explained in Chapter 2, §2.2.3, the conditions of conditional accountability are divided into two important

main conditions: goals and infrastructural arrangements (Vriens et al., 2016). Because this is a relative new approach of accountability, the conditions as described in the article by Vriens et al. (2016) cannot be related specifically to direct patient care in terms of examples as it can with calculative and narrative accountability. Indirect, the conditions of the conditional approach are present when it comes down to the tasks within direct patient care. When looking at the goals, Freidson (2011) argues that market and bureaucratic goals should not be the main goals of professionals. Only societal value goals should be the main goal. The market and bureaucratic goals are somehow related to the effects of calculative accountability as discussed before, because they are related to maximizing profit, predictability and reliability due to figures, guidelines and procedures. As also can be seen in the analysed calculative effects, the main aim of the respondents is to provide good care. This can be related to as the societal value, as Freidson (2011) and Vriens et al. (2016) argue about. The respondents (R. 1,4,6,7) state that the aim of providing good care has a positive effect on the tasks, because as long as the aim is to provide good care, the negative effect of accountability stays suppressed. However, this does not mean that the negative effects are not present. Respondent 7 states: "*In the end, I am here for only one thing. Of course I am paid by my employer to do my job, but I am here for one thing and that is to provide good care. And if I have to do that ten times a day, or eight or twelve times, it is what needs to be done.*"

Vriens et al. (2016) state that the second condition of conditional accountability, infrastructural arrangements, is divided into three parts: structure, performance management, and technological means. The respondents indicate that structure for medical professionals still is about formalization, specialization, and centralization. Despite the fact that Vriens et al. (2016) argue that professionals need an intensive technology with improvisation and intuition, the medical professionals state that they experience a positive effect with an combination between an mechanic (high values of formalization, specialization, and centralization) and an organic structure (low values: intensive technology). "*You can of course deviate from protocols and rules, and yes, you have certain safety conditions, timeouts, checklists and things like that. But to say that it is such a burden, I think it is better than expected."* Respondent 7.

The effects of calculative accountability showed that decontextualization has a negative effect. The set production quantity do not stand for the work that they actually perform and because of that medical professionals can feel undervalued. In order to restore this undervaluation of doctors, personal goals for professionals could help to overcome this.

The respondents think that more focus on performance management could have a positive effect, but on the other hand a disadvantage of the conditional form plays a role. A disadvantage is that when the calculative indicators are met, we do not need to account for the conditions that led up to these results (Vriens et al. (2016). Respondents confirm this disadvantage, because in the end, it is about the calculative indicators (R1, R5, R6).

The technological conditions are the last infrastructural arrangement as described by Vriens et al. (2016). These are the physical lay-out of the space they work in, the ICT, etc. (Vriens et al., 2016). Vriens et al. (2016, p.1186) state that "without the proper equipment, ICT, etc., professionals will have a hard time reaching their goals". Respondents state that they experience a positive effect on their tasks due to the current available equipment (R1, R2, R4, R5, R6, R7). Some years ago, medical professionals documented everything with pen and paper. Nowadays, due to the technological innovations online programs were created where professionals can document everything. Despite the fact that medical professionals experience a negative effect due to the obligation do document everything, the online programs make it easier than formerly.

4.2 Indirect patient care

Zimmer (2017) describes indirect patient care as all the activities on behalf of particular inpatients without their presence, like documentation. The analysis shows that examples according to the respondents are the reviewing of results, the assessment of certain tests like x-rays, etc. (R1, R4, R6). The definition of Zimmer (2017) also confirms the choice that was made to include documentation in both the direct patient care and the indirect patient care. For indirect patient care, an example of documentation is the documentation of the results of certain tests.

4.2.1 Calculative accountability

The definition of calculative accountability according to the theoretical framework was discussed in the first sub-section (§4.1.1). There for, the definitions of the different forms of accountability will not be repeated at every sub-section.

For indirect patient care, calculative accountability plays a role in the sense of guidelines and protocols. These guidelines and protocols are used for the assessment of different tests and for the performance of interventions on patients. Interventions of patients are indicated as direct patientcare, because the patient is actually present sometimes. Respondents see the interventions done on patients as indirect patient care (R1, R3, R5, R7).

The opinions of the respondents on the effects of the guidelines and protocols are divided. One experiences the guidelines and protocols as very disturbing and obstructed, and the other does not experience this as a problem but as part of the job. Despite the negative experiences with regard to guidelines and protocols, all respondents indicated that deviating from the guidelines and protocols is always possible, as long as the doctor can justify why he or she deviates. "*They are guidelines, protocols, and you can deviate from it with arguments."* (Respondent 5).

In the theoretical framework (§2.1) it becomes clear that nowadays, medical specialists have to account for everything they do. Back in the days, medical specialist where more trusted in decision making because of authority (R1, R2, R3, R4, R5, R6, R7). Because of the demand for accountability that has arose the last few years, the respondents indicate that the authority of medical specialists and the trust in decision making has changed and partly has disappeared (R1, R3, R6, R7). Despite the fact of decreased trust in medical specialists, the respondents indicate that because of the guidelines and protocols, the specialists work more as a team instead of being single operators. *"Let's be honest, of course you have more protocols and guidelines nowadays. You didn't even had them it in the past, but that doesn't mean it used to be better. Partly because of the protocols and guidelines, it is more a well-oiled machine. On the other hand, I also think that all protocols and guidelines make people think less, just follow the protocol." (*Respondent 4). Following the guidelines and protocols is the best choice in some cases (R2, R6, R7). For simple interventions that do not lead to much extra overthinking, following the protocol is a standard procedure. The same applies when certain doctors have to perform interventions that are not necessarily within their area of specialization. It would not be smart to deviate from protocols where deviation is not necessary (R1, R4, R6, R7).

"Yes we notice that it is very medicine by protocol. And of course, when you are going to say that everything has to go by protocol, real cookbook medicine, and you cannot deviate from it because otherwise you will get punished and you have to justify yourself. I think that would only be an impoverishment" (Respondent 4). The analysis reveals that 'cookbook medicine' is a well-known concept among doctors. By cookbook medicine is meant that everything is done according to some recipe, the guidelines and protocols. Respondents believe that due to the high amount of guidelines and protocols doctors think less and creativity fades away as result (R1, R3, R7). But also for this effect counts that despite the fact that back in the days doctors had more authorization and freedom in decision making,

that does not mean that it was better then. Like was stated above, the respondents state that there is enough room to deviate from the guidelines and protocols. What the analysis also shows is that a number of Respondents believe that the possibility to deviate from guidelines and protocols and being able to justify the made choices, comes with years of experience (R1, R5, R6). The respondents believe that deviation is more quickly accepted when a doctor has more experience. This could have an effect on the performance of work of young doctors. Because of the high amount of guidelines and protocols, the decrease in working freedom and the point that deviation would not be easily accepted, could encourage the development of the 'cookbook medicine'. It becomes a domino effect. Because young doctors grow up in a medical environment of guidelines and protocols and where deviation is possible but not always accepted, these doctors do not know better and it becomes a habit to always work according to the protocols. The respondents state that it is very important to treat every patient as unique (R1, R3, R7). The respondents also state that the guidelines and protocols are sometimes too general and in some situations you have to deviate because the patient requires a different treatment (R1). This 'cookbook medicine' would then be inferior to the care the patients really need and deserve.

With respect to documentation in relation to the indirect patient care, the patient file is also in this case the most important object. The effects of documentation with regard to direct patient care share the same effects as indirect patient care. Doctors can deviate from the guidelines and protocols as long as they can justify their actions. This justification is done in the patient file. The respondents indicate that it is very important to document the chosen actions when it comes down to deviation, because when questions are asked or something goes wrong with the patient, the documentation of the chosen action is leading in any investigation. "*But indeed, the combination of more protocols and guidelines, to think less yourself, constantly indicating why you deviate from the protocols and the assertiveness of patients. In combination with a higher workload, decrease in income, which makes me think again, I would not choose it again."* (Respondent 4). As long as deviations do not cost too much money in the eyes of the hospital and health insurances, the doctors can deviate as long as they can justify their chosen actions (R1, R3, R4, R5, R6, R7). If mistakes are made, there are a number committees who might encounter. For example, doctors can be confronted with a disciplinary and quality committee. They must be able to account for their actions and an quality investigation is conducted. The respondents indicate that making mistakes and the consequences that could be attached to them, are not immediately seen as pressure (R1, R2,

R3, R6). If a doctor deliberately makes a mistake, the respondents indicate, they are in trouble. The above quote of one respondent shows the different side of the story in which, because of all the changes in health care, he/she would not choose this profession again.

In summarization, the core tasks of indirect patient care is reviewing results, the assessment of certain tests, interventions on patients, and documentation of the results. The effect of calculative accountability on the core tasks of indirect patient care is first that the guidelines and protocols have a positive effect on the tasks because nowadays it is a more well-oiled machine. Second and last effect is that the guidelines and protocols have a negative effect for young, unexperienced doctors, because they think less and creativity fades away as a result.

For indirect patient care, the narrative and conditional form of accountability do not apply. Narrative accountability does occur when it comes down to discussion and deliberation of indirect patient care with other medical specialists. This will be analysed in the next sub-section, professional communication. With regard to the conditional approach, the same effects occur as were discussed in §4.1.3 with direct patient care. Because conditional accountability is relatively new, the approach cannot be related to specific tasks but the possible effects can be elaborated. The effects of conditional accountability on indirect patient care are the same as the effects on direct patient care.

4.3 Professional communication

In the third section, the final task group of doctors is discussed: the professional communication. Zimmer (2017) describes this as ‘general inpatient activities’, which means activities not on behalf of particular inpatients but connected with the delivery of care in general, like meetings, team discussions, etc. It could also be described as all the communication with another health professional (Ampt et al., 2008). As stated earlier in the analysis, doctors always work in teams. The teams always consist of a number of specialists and assistants. These specialists are specialized in the same area. *“We have our own staff meeting, morning transfer and afternoon transfer, IC discussion where one of us joins the meeting, and all the outpatient conversations... And there are also committees that, for example, deal with the ins and outs of emergency care. That is a separate department, so we are a guest there.”* (Respondent 3). This quote gives a brief overview of the various meetings that doctors have in regard to professional communication.

4.3.1 Calculative accountability

Professional communication in regard to calculative accountability expresses itself in the stated production figures who are already discussed in the first section (§4.1), direct patient care. The production figures is a topic that is often dealt with in the meetings that the respondents have to attend. These figures are discussed and evaluated during the meetings. These production figures are a representation of what the medical team has performed. The respondents indicate that they do not feel obligated or forced to account for the figures. All respondents state that this is 'part of the job' and as a team they are responsible for the represented figures. Concerning the advantages of calculative accountability, the transparency and openness of the figures also makes it easy to talk about in meetings. In this sense, the respondents state, it is easy to see to what extent the medical team can achieve the stated figures yes or no (R1, R5, R6). An effect that already came up in the first section, direct patient care, is also applicable on the professional communication. Despite the fact that the figures are transparent and open, the figures do not show the situations where doctors are actually in. The disadvantage of decontextualization also plays a role in professional communication. The analysis does show that decontextualization does not plays a role in every meeting. The respondents state that it depends on what kind of meeting it is, because some meetings where the figures are discussed are with the own team members (R3-R4). Here everybody knows in what kind of situations the doctors are in. When it comes to the effects of the stated production figures in relation to the professional communication, the statement of being 'part of the job' has the upper hand and therefor the respondents do not experience effects that influence how doctors perceive their tasks.

Calculative accountability thus has a positive effect on the core tasks of professional accountability (meetings and team discussions), because the figures give a transparent image of how the whole team is performing and if the team achieved the stated figures.

As what is stated in the introduction of the analysis, the task group 'documentation' is divided among the direct (§4.1) and indirect patient care (§4.2). Therefore, documentation is no part of this task group as it was in the previous two sections.

4.3.2 Narrative accountability

Narrative accountability is the most common form of accountability that occurs when it comes down to professional communication according. Doctors are constantly in contact with other medical specialists.

"You remain responsible and that means that you must also be able to give account. That is difficult sometimes and that also means that you have the rights to say to others, why did you do that, I do not agree or I do not think that is good because for that and that reason." (Respondent 4). Doctors are, in a certain way, obligated to point each other on errors and mistakes. When it comes to professional communication, doctors sometimes have to account for the made choices or discuss certain options. The respondents indicate that the obligation to give account also creates the possibility to ask questions to colleagues about their made choices.

Professional communication also provides the opportunity to discuss certain cases with other medical specialists. The respondents experience this as very helpful. "*Sometimes things are very easy and then you have a very clear image of what should happen. But when it is not very clear it is very nice to be able to consult each other briefly, based on everyone's own expertise. And such a discussion has a real added value."* (Respondent 7). One of the advantages of the narrative form of accountability is that it provides context and gives the possibility to have some form of dialogue (Kamuf, 2007). These two advantages are confirmed according to the respondents (R1, R4, R6, R7). The quote shows in which situations it could be very helpful to be able to discuss and negotiate with other medical specialists with expertise different than the one of the doctor him or herself.

In summary, narrative accountability has a positive effect on the core tasks of professional accountability because it improves the possibility to communicate with other professionals in situations when things are uncertain or unclear.

4.3.3 Conditional accountability

The developed conditional form of accountability is really focussed on the professional, in this case the medical specialist (Vriens et al., 2016). As was discussed in §4.1.3, conditional accountability is a relative new approach. Therefore, the conditions as described in the article by Vriens et al. (2016) cannot be related specifically to professional communication. Doctors indicate that conditional accountability is a form of accountability that is not consciously used by medical specialists or the hospital, but it does play a role in professional communication with regard to performance management from the infrastructural arrangement by Vriens et al. (2016).

Performance management from the infrastructural arrangements plays a role in the way doctors are assessed for the performance of their work. Respondents indicate that

conditional accountability is performed by the use of the benchmark assessment and the POP (Persoonlijk Ontwikkeling Plan; Personal Development Plan) (R1,R3). Vriens et al. (2016) identify two general influencing conditions based on different literature, namely the goals and the infrastructural arrangement. The infrastructural arrangement consists of three aspects that directly could influence the way professionals carry out their work. Performance management systems is one of these three aspects described by Vriens et al. (2016). This aspect is used to select, assess, appraise, monitor, reward, sanction, motivate and develop professionals and their performance. The two types of assessment that are mentioned above could be classified under these performance management systems.

"Look, with figures it is very easy. You agree in advance that we want to see a hundred patients after a year. Yes, look, when you say that someone should be empathetic as an action point, what the hell is empathic? How relevant is what you measure reliably for a medical specialist for the performance of his profession. That is very different per specialist." (Respondent 3). With the use of the benchmark assessment, where colleagues are asked to assess each other, and the POP, the attention is on the medical specialist and his or hers performance. The respondents have the feeling that, at this moment, there is too little attention for the professional (R1, R2, R7). What the quote indicates is that it is very difficult to describe an action point that is applicable for every medical specialists. In this sense, the disadvantage described by Vriens et al. (2016) is confirmed that the conditions do not guarantee ideal-type professional conduct. In regard to the quote stated above, when a doctor is emphatic according to some rules it does not mean that the performance of his or hers profession is correct.

The effect of conditional accountability on the core tasks of accountability is that it is very difficult and therefor negative to determine certain goals or infrastructural arrangements for professionals because it does not guarantees the ideal-type of professional communication.

4.4 Overall effects

When analysing the results of the interviews, some interesting findings were found that not directly were related to the three task groups described above. There for, a fourth section is added where the overall effects are described who are of influence to answer the research question. By describing the effects, the usefulness is also described.

4.4.1 Discrepancy between the terms accountability and responsibility

For this research the definition of Bovens (2007) is used a guide. Bovens (2007) states that accounting is a relationship between actor and forum, in which the actor has an obligation to explain and justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences. This definition of Bovens (2007) can be confirmed by the respondents (R1, R2, R3, R4, R5, R6, R7).

"*Yes, well, responsibility is of course that you provide good care. You must be able to support that. That you believe that and others also, that you get feedback for what you're doing. In addition, you have to deal with your patients in a correct way, that goes without saying. That you handle your responsibility and that you can clearly explain something about what you do and what your findings are."* (Respondent 4). The quote shows that the respondent almost completely supports the definition of Bovens (2007). What is interesting in the different definitions of accountability that are given, the term 'responsibility' is often used. For the respondents there is a clear difference between being accountable and being responsible, while these terms are used interchangeably by many. Without dwelling on it, accountability is used as responsibility and vice versa. What is interesting is that a number of respondents (R4, R6, R7) see the concept of accountability as something negative, something that is beyond the scope of the profession. Accountability is often associated with mistakes or certain choices that doctors have to account for. "*It has a very negative sound, accountability. For doctors in general. We are accountable to the inspection, to the board, to the disciplinary court. In any case, they are always negative things. And accountability also has the sound of something has gone wrong and you just go and explain why it went wrong and how it is possible that something goes wrong at all."* (Respondent 7).

The discrepancy between the two concepts has no direct effect on the three different task groups that are discussed in the analysis, but does has an effect on the definition of the forms of accountability and thus on the answering of the research question. Because of the effect of the discrepancy on the definition of the three forms of accountability, the effects on the different tasks could also be effected because doctors perceive accountability differently. Accountability is associated with what needs to be brought out to society and authorities. "*I can feel responsible about something and not have to account for it. But it may also be that others think that I am responsible for something and then I have to justify myself."* (Respondent 6). This quote shows the difference between feeling responsible and being responsible for something. On the basis of this quote in relation to the definition of

accountability given by the respondents, this 'being responsible' could be identified as accountability because other people or instances desire a justification.

Most of the times, the respondents perceive calculative accountability as accountability in terms of justifying what choices the medical specialist has made in terms of numbers or standard procedures (R1, R2, R4, R7). The respondents state that the performance of the standard procedures is not always perceived as being accountable. The documentation of the made choices on the other hand, is perceived as accountability. As is already stated in the analysis, some respondents experience this documentation as inferior to what a doctor should really do, provide good care.

Narrative accountability is to account in the form of explaining to and discussing with others reasons for conduct (Vriens et al., 2016). The respondents do not experience conversations with patients as accountability, but as responsibility. "*….That you handle your responsibility and that you can clearly explain something about what you do and what your findings are."(*Respondent 4). Section 4.3, professional communication, has also shown that the conversations and meetings with colleagues are not directly perceived as accountability, but also as responsibility of the profession of being a doctor. Vriens et al. (2016) already state the narrative form of accountability is an insufficient form of public professional accountability because for outsiders other than the professionals it is difficult to understand the complicated information. The analysis about the discrepancy of the concept accountability and responsibility could be a reason to assume that narrative accountability, by the statements of the respondents, is not perceived and there for is no form of accountability for medical specialists. Narrative accountability is rather a part of the responsibility a medical specialist carries. *"I perceive accountability as extrinsic. Responsibility is something that is intrinsic and I believe that is the most important part of being able to provide good care to patients.*" (Respondent 6).

As was stated before, the discrepancy between accountability and responsibility has no direct effect on the tasks of doctors but it does has an effect on the definition of accountability as perceived by doctors and therefor it has an effect on answering the research question. This influences the research question because when a form of accountability is different or not perceived as accountability, it changes the perspective on the effects on the tasks of doctors and there for it is relevant to take into account.

4.5 Summary

The analysis shows different insights into the impact of accountability on how doctors perceive the effect of the three forms of accountability on their tasks. The first section, direct patient care, is the section where accountability plays a big role. The different forms of accountability have different effects. Calculative accountability causes decontextualization according to the respondents. The set outpatient times in relation to the production figures do not show the real situation that the doctors are in. The patients in this sense become a number, instead of a unique patient. The respondents state that it is very important to treat every patient as unique. Despite this, the respondents indicate that poor professional performance is not applicable. Documentation in regard to direct patient care is experienced as inferior to what a doctor should do, providing good care. This takes time, but is also indicated by the respondents as 'part of the job'. Narrative accountability in regard to direct patient care also causes effects. The analysis for example shows that trust is still an issue and this is also a reason why patients now a days are more articulate. It is sometimes also difficult for patients to understand what a doctor tries to explain because of the short outpatient times. Here narrative and calculative accountability have a relation to each other. With regard to conditional accountability, the goal of societal value can be related to the main purpose of being a doctor, providing good care. The respondents indicate that this goal has a positive effect on the tasks. The respondents also indicate to experience positive effects due to the combination in structure between the mechanic and organic structure. There are guidelines and protocols, what can be related to mechanic structure, but doctors can deviate from them when they can account for made choices and actions, what can be related to the organic structure. Further for conditional accountability it is difficult to relate the approach to specific tasks because it is a relative new approach and there has not been much research yet.

With regard to indirect patient care, doctors always have the chance to deviate from standard protocols and guidelines when they can justify their made choices. The respondents state that because of the guidelines and protocols, it is more a well-oiled machine and it provides structure. This is accompanied by the statement that 'cookbook medicine' arises, where everything is done according the protocols and creativity slowly disappears. For young doctors this is of most influence, because they grow up in a working environment where deviation is possible but not always accepted for young doctors.

Professional communication is experienced as helpful and part of the job. The production figures are sometimes discussed in meetings and here the disadvantage of

decontextualization occurs, but the concept of ‘part of the job’ has the upper hand. The possibility to have a dialogue with colleagues is experienced as helpful, because in difficult situations there is the possibility to have a consult with other medical specialists. With this, the responsibility is carried by the team. Concepts around conditional accountability like a Personal Development Plan is experienced as difficult by the respondents. This because it is very hard to identify per specialism what kind of action point of conditions are applicable. Also here, the disadvantage that the calculative indicators have the upper hand is applicable.

Eventually, the overall effect of discrepancy between the concept of accountability and responsibility plays a big role in how doctors perceive the effect of the three forms of accountability on their duties. There is a big difference between accountability and responsibility in the eyes of the respondents. Accountability is perceived as something that is extrinsic and responsibility is intrinsic. For example, the production figures are an extrinsic part where accountability is desired by other instances. A conversation with patients is experienced as intrinsic and part of the profession. This intrinsic part is of most value to the respondents. The profession is about providing good care to patients.

An illustrative summary is provided in the next table. Here a short summary is illustrated of the four task groups as explained in the conceptual model, examples according to the respondents, the three forms of accountability, how they take place according to the respondents, and the effects of the three forms on the tasks groups. The overall effects are left out of this table, because they are not directly related to the three task groups.

Definitions and examples	**Calculative accountability**	**Narrative accountability**	**Conditional accountability**	**Effects of the 3 forms**
Direct patient care "*All tasks directly related to patient care, including direct communication with patients" (Ampt et al., 2008)* ● Outpatient visits ● Interventions ● Documentation	Account in terms of following procedures and rules, or working to predetermined targets and standards (Vriens et al., 2016)**.** **Takes place by,** Production figures	Account in the form of explaining to and discussing with others reasons for conduct. **Takes place by,** Outpatient conversations	Account in the form of conditional (goals, infrastructural arrangements) enabling professional conduct and its results. **Takes place by,** Does not apply	● Doctors experience too little time ● Negative to put patients within the same framework ● Decontexualization ● Provides opportunity to have some form of dialogue with patients ● Patients do not always understand ● Takes a long time to document everything ● Online programs make documentation easier than before
Indirect patient care "*All activities on behalf of the patient without their presence"(Zimmer, 2017)* ● Reviewing results ● Assessment of certain tests ● Planning care ● Documentation	Guidelines and protocols used for the assessment of tests, performing certain interventions & planning care	Does not apply	Does not apply	● Positive to work more as a team ● Negative effect on young doctors because they think less ● Takes a long time to document everything
Professional communication *"General inpatient activities, activities not on behalf of particular inpatient but connected with the delivery of core in general, like meetings." (Zimmer, 2017).* ● Meetings ● Performance reviews ●Commissions ● Communication with other professional about treatments	Protocols and set production figures	Justify for actions and choices made	Benchmark Pop (personal development plan)	● Transparency of figures makes it easy to talk about ● Obligation provides the possibility to ask questions and discuss certain actions ● Difficult to determine certain goals or infrastructural arrangements because it does not guarantee ideal-type of professional conduct

Table 4: Overview analysis

5. Discussion and conclusion

In chapter four the findings from the interviews were analysed, compared and linked to the three different forms of accountability. In this chapter this link between the three different forms of accountability and the impact on the tasks of doctors is further elaborated. First, the conclusion (5.1) will give the answer on the research question. The contribution to knowledge will be further elaborated in the theoretical implications (5.2), the practical implications (5.3), the limitations (5.3), and finally the recommendations for further research (5.4).

5.1 Conclusion

The goal of this research was to investigate and increase the knowledge about the relation between the different forms of accountability and the tasks of doctors, and how medical professionals perceive the effects of this relationship. The following research question was defined: "*How do doctors perceive the impact of the three different forms of accountability on their tasks and duties?".* Table 1 (p. 18-19) shows the comparison of the three different forms of accountability. The three forms of accountability are linked to the four different sub-tasks of medical specialists according to the KNMG (2007). This link caused the development of the conceptual model (Figure 1, p.21) what is used to investigate how doctors perceive the effect of the three different forms of accountability on their tasks. When analysing the findings, the four task groups as described in Chapter 1 are reduced to three task groups: direct patient care, indirect patient care and professional communication. The conclusion is built on the basis of the three different forms of accountability.

Calculative accountability has the most impact on the tasks of direct patient care, in particular the outpatient visits. Direct patient care contains all tasks that are directly related to patient care, incl. direct communication with patients. With regard to the outpatient visits, there are set outpatient times introduced. The set outpatient times causes that patients are put in the same framework. Patients are not classified according to their level of difficulty, but according to the set figure that must be obtained. The most important factor in the profession of a doctor is the providing of good care. Providing good care contains the possibility to inform the patient well, in terms of examinations, intentions, expectations, and the risks. Calculative accountability, in the form of set outpatient times, negatively impacts the providing of good care in some of the cases, and therefore negatively impacts this task of doctors. In order to provide good care, doctors try to give the patients the time they need and deserve. In some cases when patients have different injuries, diagnostics or when they are older, they need more time in order to inform the patient well. In combination with the

obligation to document everything into the patient files, the workload of doctors becomes higher. It can be concluded that documentation is a task that no professional finds pleasant and it feels inferior to what a doctor should actually do, providing care. It takes a long time to document everything and in some cases this is at the expense of the time that the patient needs. Despite the fact that it takes a long time and feels inferior to what a doctor should actually do, it can also be concluded that doctors do not feel much pressure because of documentation. Indirect patient care is about all the activities on behalf of particular inpatients without their presence, like documentation and the reviewing of results. Indirect patient care is only effected by calculative accountability. For indirect patient care, the biggest effect is caused by the protocols and guidelines that are need to be used when providing care. The medical specialists state that the guidelines and protocols have a positive impact on the amount of teamwork that is present these days. Some years ago, when there were less guidelines and protocols, doctors worked more as individuals and now a days it is more a well-oiled machine. A down side to all guidelines and protocols is that cookbook medicine becomes a normal concept in health care. Doctors think less for themselves and creativity fades away. Doctors perceive this concept of cookbook medicine as something negative for young, unexperienced doctors. Where experienced doctors can deviate easily from protocols and guidelines as long as they can account for their made actions, the doctors state that this is more difficult for young experienced doctors. By this, the young doctors get used to health care arranged by protocols and guidelines while some patients require treatment that differs from the stated guidelines and protocols. Professional communication is about activities not on behalf of particular inpatients but connected with the delivery of core in general, like meetings. Medical specialists only experience positive impacts on the tasks of professional communication in relation to calculative accountability. One of the advantages of calculative accountability is that the figures are transparent and open. This advantage has a positive impact on all the meetings medical specialists have with regard to these figures because the transparency makes them easy to talk about.

Narrative accountability is giving account in the form of explaining to and discussing with others reasons for conduct in a way that allow for freedom. With direct patient care, narrative accountability has an impact on the outpatient conversations. The medical specialists state that because of the information that is available on the internet, patients and relatives become more assertive and this provides the possibility to have a more in depth conversation. A negative impact of narrative accountability, what is in relation to the negative effect of the

set outpatient times with calculative accountability, is that in a short time the medical specialists need to explain difficult things to the patients. Providing good care is also about informing the patients well, and medical specialists state that it is difficult to let the patient participate in the decision-making process because they are not medically qualified. Patients can function at very different levels in terms of intelligence, what makes the process of informing the patient difficult sometimes. With regard to professional communication, the medical specialists experience a positive impact of narrative accountability. Medical specialists are obligated to point each other on errors. They state that this does not feel like an obligation, but it has a positive effect on the tasks with regard to professional communication because it provides the possibility to ask questions and discuss certain actions. This improves the providing of good care.

Conditional accountability focusses on the conditions enabling professional conduct and its results. This form of accountability is a relatively new approach and there has not been much research done. Here for, conditional accountability cannot be related to specific tasks as can be done with the calculative and narrative form. However, conditional accountability has some positive effects on the tasks of doctors. The societal value should be, according to Vriens et al. (2016), the main goal of a professional. The doctors perceive providing good care as their main goal what could be related to the societal value of conditional. This main goal has a positive effect on the tasks of doctors.

Thus, one can conclude that doctors perceive the impact of the three forms of accountability on their tasks differently. The greatest impact on the tasks of doctors comes from the calculative form. The impact is both negative and positive. When it comes to the overall effects of the three forms, this research has revealed that there is an important contradiction between accountability and responsibility according to the doctors. This also has an effect on the impact of the three forms on the tasks, because the research shows that different effects occur and could occur when taking the two concepts separately.

5.2 Theoretical implications

As already described in chapter one, over the past few years, a trend has developed that professionals in various sectors have to justify their actions to a wide audience (Vriens et al., 2016). Currently, there are three ways of accounting: calculative, narrative and conditional accountability (Vriens et al., 2016). These three forms of accountability all have their own advantages and disadvantages as explained in Table 1 in §2.2.4. Medical professionals have

much different tasks that are divided among two levels of tasks, patient level and professional group level. The KNMG manifest (2007) and Ampt et al. (2008) describe four task groups related to these two levels: direct patient care, indirect patient care, documentation, and professional communication. This research aimed to give further knowledge into the relation between the different forms of accountability and the different tasks of doctors, and to uncover how doctors perceive the impact of the different forms on their tasks and duties. This was achieved by collecting empirical data from medical professionals on the basis of a conceptual model in §2.5 that displays the relation between the three forms of accountability and the four task groups. During the analysis of the empirical data, there was found that the task group 'documentation' overlapped too much with the task groups 'direct patient care' and 'indirect patient care'. Therefore, documentation was divided among these two task groups.

Vriens et al. (2016) illustrate that the narrative form of accountability is giving account in the form of explaining to and discussing with others reasons for conduct that in a way allows for freedom. For example, a doctor explaining a diagnosis to a patient. Kamuf (2007, p.252) states that this form of accountability has almost no chance of making the intention understood given the inertia of habitual usage. This research indicated that it is not only difficult for outsiders like the health insurance, as Vriens et al. (2016) state, but that it is also difficult for patients to always understand the difficult terms and information the medical professional provides. Vriens et al. (2016) perceive the narrative form of accountability as an insufficient form of professional accountability. This research showed that medical professionals do not experience direct effects on their tasks due to narrative accountability, because narrative accountability as it is described by literature, is not perceived as accountability by the professionals. For Table 1 in §2.2.4 this might implicate that the theoretical constructs for this form of accountability for this profession should be better delineated or critically reviewed.

Additionally, accountability has been a concept that has not always been understood well. Literature shows that there are different definitions of the concept of accountability. For this research, the definition of Bovens (2007) was used as a guide. Bovens (2007, p.450) describes accountability as: "Accountability is a relation between an action and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the form can pose questions and pass judgement, and the actor may face consequences." During the research it became clear that the concept of accountability is indeed not always understood

well. From a superficial point of view, the definition of Bovens (2007) is also applicable on doctors in hospitals. Medical professionals have an obligation to different forums where they have to explain and justify their conduct. The results of the research showed that medical professionals perceive this concept not as superficial as is explained above. There is an important discrepancy in the definitions given by medical professionals. The different definitions in literature use the term responsibility as a distinct concept of accountability and also the medical specialists use the term responsibility in their definition of accountability. There is a difference in feeling responsible and being responsible. This 'being responsible' is perceived by the doctors as accountability, because forums demand for justification. In researching how medical professional perceive the impact of the three different forms of accountability, some effects occurred because of the effects of accountability and some effects occurred because of the effects of responsibility. Medical professionals state that responsibility is something that cannot be prescribed in terms of procedures, guidelines or predetermined targets. Responsibility is an intrinsic motivation, where accountability is extrinsic. One important example is a disadvantage of calculative accountability stated by Vriens et al. (2016) as the most important problem of calculative accountability namely, decontextualization. With this disadvantage Vriens et al. (2016) state that professionals need to account for something that abstracts from the specific situations professionals have to respond to. Decontextualization does is a negative effects that occurs because of calculative accountability, but it is an effect on the responsibility of professionals. Decontextualization is an intrinsic effect that occurs because of the extrinsic obligation to account in terms of following procedures and rules, or working to predetermined targets and standards. In this term it does not have a direct impact on the tasks of medical professionals, but it could be a cause for effect when professionals lose their intrinsic responsibility. Below a table can be found where the impact of the three forms of accountability are described due to accountability or responsibility.

Effects due to,	**Accountability**	**Responsibility**
Calculative accountability	● Doctors experience too little time with outpatient conversations ● Negative to put patients within the same framework ● Doctors spend allot of time on	● Decontextualization

	documentation ● External instances can decide without medical knowledge	
Narrative accountability		● Pleasant to have a more in-depth conversations with patients because of information available on the internet ● Negative to put patients within the same framework; not every patient is well-informed or has the capabilities to understand the information
Conditional accountability	● Positive effect with a combination in the mechanic and organic structure ● More performance management could have a positive effect, but is difficult to implement	● Positive effect of having a societal value, namely the providing of good care

Table 5: Overview effects due to accountability and responsibility

The above table shows that the three forms of accountability do have an impact on the tasks of medical specialists, but this research indicated that there is a difference between what medical professional understand as accountability and responsibility. Therefore, it can be argued that this research indicated that there would be more effects when the concepts are taken separately than that have come up with the conceptual model from §2.5 where the three forms of accountability are taken into account as described by Vriens et al. (2016).

5.3 Practical implications

The aim of this research was to give further knowledge into the relation between the different forms of accountability and the different tasks of doctors, and to uncover how doctors perceive the impact of the different forms of accountability on their tasks and duties. Therefore, this research gave a more theoretical understanding of the relation between the different forms of accountability and the different tasks of doctors. This research also provided a practical contribution to the understanding of this relation. The results of this research analysed in chapter 4 presented whether the three different forms of accountability (calculative, narrative and conditional) have a positive or negative effect on the different tasks in the three task groups of doctors (direct and indirect patient care, and professional communication). This link provided insights for organizations in understanding the effects of

accountability on the tasks of professionals. This is of practical relevance and value because of the pressure that doctors experience according to different literature articles. For example, Becker et al. (2010, p.8) state that because of accountability "short doctor-patient communication make patient centred care more difficult which results in the physicians' dissatisfaction with their work (environment)" related to the pressure because of documentation. There is found that medical professionals have a different perception of the concept of accountability in their tasks. For example there is found that doctors do not perceive the conversations with patients and colleagues as (narrative) accountability. Therefore, this research contributed to the understanding in what way the concept of accountability as it is described in literature is present among the professionals. Understanding what the true effects of accountability as perceived by medical professionals on their tasks are reveals where the pressure really lies when it comes down to the different task groups. This knowledge could prevent medical professionals from performing poor professional conduct. Further research is needed to gain concrete insights in how medical professionals perceive accountability and what the effects are on their tasks and professional conduct. This research provided the starting point for discussion in organizations about in what way the three forms of accountability are presented and how they are perceived by professionals related to their tasks.

5.4 Limitations

All research suffers from limitations. A number of limitations came to light during the performance of this research. The first limitation is that because of difficulty with finding respondents the research only provided the empirical results of professional from four hospitals. With a larger scope, different and more effects of the three different forms of accountability could have been found.

Second, the elaboration of the relation between the three forms of accountability and the effects on the tasks of doctors seemed relevant at first. After analysing the results, it turned out to be very difficult to relevantly elaborate on the relationships between the three forms and the effects on the tasks. This seemed to be a relevant question in the first place, because there not yet had been a research were the three forms were combined in relation to the tasks of a particular profession. It seemed interesting to investigate how doctors perceived this relation between the three forms and the effects on their tasks because of the commotion around the work pressure doctors should experience due to the increased demand of accountability. This turned out to be difficult because of the discrepancy medical

professionals perceive against the concept of accountability. Accountability as medical professionals perceive this concepts, turns out to have more effect on the intrinsic need of professionals to provide good care. The aim of this research was to investigate the effects on the tasks of doctors. Because of the above described discrepancy, the relation between the three forms and the effects on the tasks were difficult to elaborate.

A third limitation of this research is that the developed interview changed during the research. The first developed interview guide did not directly answered the research question, so the choice was made to change the interview guide. Because of this, validity of the research is not totally covered because not all the answers given by the first respondents measure what they should measure.

5.5 Recommendations

The findings in this research resulted in two recommendations for further research. This research showed that there is a discrepancy between what in literature is understood by and what medical professionals understand by the term accountability. The two concepts accountability and responsibility are interchangeably used by many, also by medical professionals. This research investigated the relation between the three different forms of accountability and how they have an impact on the tasks of doctors. It became clear that because of this discrepancy, different effects could arise when accountability and responsibility were separately used as concepts. Therefore it would be interesting to investigate the true distinction between these two concepts according to medical professionals and how they impact the performance of good care. Maybe, because of this there can be investigated how heavy accountability really loads on the professionals.

Secondly, this research showed that medical specialists do not have the same professional autonomy as some years ago due to all the guidelines and protocols and the development of accountability. The research showed that young, unexperienced doctors cannot deviate from these guidelines and protocols as easy as experienced doctors. Providing good care is the most important facet of a medical professional. Now a days, some external instances have the power to decide how good care needs to be performed by medical professionals. Medical specialists now a days have less freedom to provide good care according their own knowledge, experience and expertise. It would be interesting to do a qualitative research into the degree of freedom and the degree in which external instances interfere in concrete situations.

5.6 Researcher's reflection

This master thesis was based on the article written by Vriens et al. (2016) about the developed conditional form of accountability. On the basis of former research into the three forms of accountability independently of each other, the question arose how the three forms together present themselves in practice. Articles concerning the three forms of accountability are therefore used in the development of the theoretical part. Due to the presence of health care in literature and news articles and the pressure that doctors experience through accountability and documentation, this was an interesting combination and relationship to investigate. In addition, there has not yet been done a study into the effects of the three forms on one specific profession. It was already noted during the development of the literature phase that the subject of accountability is very broad and that there are various facets within health care in this area that are currently being discussed in the media as well as in articles. The results of this research produced a number of interesting findings in the area of accountability, such as the contradiction among doctors between the concept of accountability and responsibility. As a researcher I noted that this contradiction was perhaps more interesting than the effects on the tasks. On the other hand I am proud that this insight is obtained with the results of this research. Accountability in health care is a very interesting and broad subject. I believe that the insights of this research are an interesting starting point for further research in order to contribute to the knowledge about the concept of accountability for medical professionals.

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Appendix A Old interview guide

Thank the interviewee

Phase 1: Introduction

1. *Could you tell something about yourself?*
2. *What does a working day look like for you?*

Explain the three different forms of accountability and their advantages and disadvantages by showing Table 2. Ask if he/she understands and recognizes the three different forms of accountability. If so, continue. If not, explain better.

Phase 2: Direct patient care

3. *What does a patient review look like?*
4. *How do you experience the reviews with the patients?*
5. *In what way do you have to give account during these reviews?*
6. *In what way do you have to deal with protocols and rules during these reviews?*
7. *To what extent are expectations set by the hospital when it comes to direct patient care?*
8. *How do you feel about the production quantity that is set by the hospital when it comes to these patient reviews?*
9. *In what way are you obliged to give an oral explanation of certain matters?*
10. *In what way do you feel that patients always understand you?*
11. *To what extent do you think that the way of accounting when it comes to direct patient could be improved?*

Phase 3: Indirect patient care

1. *In what way do you have to deal with accountability when you analyse the results of a patient?*
2. *To what extent are you dealing with protocols and rules here?*
3. *To what extent are you obliged to consult with colleagues when it comes to analysing a test? And how do you feel about this?*
4. *In what way is a certain expectation set by the hospital when analysing results?*
5. *To what extent do you experience this as positive or negative?*

6. *To what extent do you think that the way of accounting when it comes to indirect patient care could be improved?*

Phase 4: Documentation

7. *How much time do you spend on documentation?*
8. *Why do you spend so much time on documentation?*
9. *How do you feel about spending so much time on documentation?*
10. *What potential problems occur during this documentation?*
11. *What could potentially solve these problems?*

Phase 5: Professional communication

12. *How do you experience all the different meetings you have with colleagues?*
13. *In what way do you experience accountability during these meetings? How do you feel about this?*
14. *What problems occur during these meetings?*
15. *What could potentially solve these problems?*

Appendix B New interview guide

Thank the interviewee for participating.

Phase 1: Introduction

1. *Can you tell something about yourself?*
2. *What does a working day look like for you?*

Explain the three different forms of accountability and their advantages and disadvantages by showing Table 1. Ask if he/she understands and recognizes the three different forms of accountability. If so, continue. If not, explain better.

Phase 1: Accountability

3. What does ’being held accountable’ mean for you?
4. In what way do you notice that the way of giving account has changed over the past few years?
5. Within which tasks do you have to give account and in what way?

Phase 2: Direct patient care

6. *The next quote states*: *"care according to protocol is good, but does not have to be good care", how do you experience this?*
7. *To what extent do you notice that the concept of "providing good care" is changing?*
8. *According to the Civil Code, you are obliged to inform patients in a clear manner about the examination, treatment and health status of the patient. To what extent does this feel like accountability to you? Are you experiencing problems with this?*
9. *To what extent can you still provide good care through documentation and all the guidelines and protocols?*
10. *To what extent is each patient still unique to you?*
11. *To what extent do you experience that there is too little room for feelings, vulnerability, etc.*
12. *As a doctor, can you always meet the expectations that are created of you?*

Phase 3: Indirect patient care

13. *To what extent do you experience that the guidelines and protocols influence the workability and findability of doctors?*
14. *To what extent can you still give your own interpretation to the performance of your duties?*
15. *To what extent is cookbook medicine involved?*
16. *A report has revealed that complaints and disciplinary procedures show that doctors often still fall short when it comes to trust, treatment and communication. What do you think about this?*
17. *Through the Healthcare Insurance Act, quantitative standards have been introduced to determine whether doctors are doing their job well in order to achieve greater transparency. According to the literature, this does not do justice to the work of professionals. How do you experience this?*

Phase 4: Documentation

1. *On which tasks do you spend time on documentation?*
2. *How do you experience this?*
3. *To what extent do you experience documentation as time-consuming and annoying?*

Phase 5: Professional communication

1. *To what extent do you notice within the department that there is a difference between what is understood by accountability?*
2. *To what extent do you feel you need to account towards your colleagues?*
3. *To what extent do you have to justify yourself when it comes to communication with colleagues? How?*

Appendix C Conceptual framework used for analysis

Definitions and examples	Calculative Acc.	Narrative Acc.	Conditional Acc.	Effects of the 3 forms
	Account in terms of following procedures and rules, or working to predetermined targets and standards	Account in the form of explaining to and discussing with others reasons for conduct.	Account in the form of conditions (goals /infrastructural arrangements) enabling professional conduct and its results.	
Direct Patient Care All tasks directly related to patient care, incl. direct communication with patients (Ampt et al., 2008). P1	Calculative acc. takes place by… P2	Narrative acc. takes place by… P3	Conditional acc. takes place by… P4	E1
Indirect Patient Care Any records of patient information on paper or computer, excl. medication (Ampt et al., 2008). I1	I2	I3	I4	E2
Documentation All the activities on behalf of particular inpatients without their presence, incl. documentation (Zimmer, 2017) D1	D2	D3	D4	E3
Professional Communication General inpatient activities, activities not on behalf of particular inpatient but connected with the delivery of care in general, like meetings (Zimmer, 2017). All communication with another health professional not related to medication (Ampt et al., 2008). C1	C2	C3	C4	E4

Appendix D Updated interview scheme

Info arts	1. Kunt u wat over uzelf vertellen? 2. Hoe ziet voor u een werkdag eruit?
Algemene verantwoording	3. Wat verstaat u onder verantwoording moeten afleggen? 4. Op wat voor een manier merkt u dat de manier van verantwoording afleggen is verandert? 5. Binnen welke taken van u moet u verantwoording afleggen en op wat voor een manier?
(P) Directe patiëntzorg	1. Quote “zorgen volgens protocol is goed, maar hoeft geen goede zorg te zijn”, hoe ervaart u dit? 2. In hoeverre merkt u dat het begrip “leveren van goede zorg” verandert? 3. Volgens het Burgerlijk Wetboek bent u verplicht om patiënten op een duidelijke wijze in te lichten over onderzoek, de behandeling en de gezondheidstoestand van de patiënt. In hoeverre voelt dit voor u als verantwoording? Ervaart u hier problemen mee? 4. In hoeverre kunt u door documentatie en alle richtlijnen en protocollen nog goede zorg verlenen? 5. In hoeverre is elke patiënt voor u nog uniek? 6. In hoeverre ervaart u dat er te weinig ruimte is voor gevoelens, kwetsbaarheid, etc. 7. Kunt u als arts altijd voldoen aan de verwachtingen die van u worden geschept?
(I) Indirecte patiëntzorg	8. In hoeverre ervaart u dat de richtlijnen en protocollen de werkbaarheid en vindbaarheid van artsen beïnvloedt? 9. In hoeverre kunt u nog eigen invulling geven aan de uitvoering van uw taken? 10. In hoeverre is er sprake van kookboekgeneeskunde? 11. In een rapport is naar boven gekomen dat uit klachten en tuchtprocedures blijkt dat artsen nog vaak tekort schieten als het gaat om vertrouwen, bejegening en communicatie. Hoe

	denkt u hierover? 12. Doormiddel van de Zorgverzekeringswet zijn er kwantitatieve maatstaven geïntroduceerd om te bepalen of artsen hun werk goed doen om zo meer transparantie te realiseren. Volgens de literatuur doet dit geen recht aan het werk van professionals. Hoe ervaart u dit?
(D) Documentatie	13. Met welke taken bent u tijd kwijt aan documentatie? 14. Hoe ervaart u dit? 15. In hoeverre ervaart u documentatie als tijdrovend en vervelend?
(C) Communicatie	16. In hoeverre merkt u binnen de afdeling dat er verschil is tussen wat onder verantwoording wordt verstaan? 17. In hoeverre voelt u een verantwoording tegenover uw collega's? 18. In hoeverre moet u zich als het gaat om communicatie met collega's verantwoorden? Op welke manier?