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Prying eyes

A dramaturgical approach to professional surveillance

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This study examines how professionals engage with the increased surveillance of their daily work. We analyze professional surveillance at the micro-level of interaction, by building a dramaturgical approach to professional surveillance. Based on qualitative interviews and observational data of healthcare professionals using a new technology to communicate simultaneously with each other and individual patients, we analyze how professionals use different elements of the theater to enact surveillance. The significance of our contribution lies especially in the dramaturgical reconceptualization of surveillance as enacted, making it an integral part of displaying one's professionalism.

Keywords: dramaturgy, healthcare, micro-level of interaction, professional surveillance

INTRODUCTION

Professionals have traditionally been characterized by highly specialized knowledge, long periods of training, and high status and autonomy (Muzio, Brock, & Suddaby, 2013; Noon, Blyton, & Morrell, 2013). Nowadays, the daily practice of contemporary professionals is increasingly under surveillance. Driven by macro-regulations stemming from the 'audit society, autonomy has made way for auditing and professionals are increasingly watched from the outside (Adler & Kwon, 2013; Power, 1997). As a consequence, professionalism is no longer self-evidently established and has become something that professionals should constantly and repeatedly prove (Mulgan, 2000).

Although earlier studies have emphasized how macro-regulations intrude into professionals' autonomy (Adler & Kwon, 2013; Rosenthal, 2004), less is known about professionals' complex engagement with increased surveillance at the micro-level of interaction. A few studies give initial insights into individuals' active engagement with increased surveillance in their daily work, showing how professionals grapple with watching eyes (Brivot & Gendron, 2011; Gleeson & Knights, 2006; Iedema, Rhodes, & Scheeres, 2006; Noordegraaf, 2011; Rosenthal, 2004). To this emerging strand of research, we contribute a deeper understanding of micro-level interactions by answering the research question *how do professionals engage with surveillance in their daily work*. In answering this question, we will construct a dramaturgical approach to professional surveillance.

Dramaturgical approaches are largely based on Erving Goffman's (1959) work, in which he uses the theatrical metaphor to show how people's daily interactions can be seen as performances. In performances, people strive for making a good impression and avoiding a negative one in front of an audience, and try to maintain order (Kivisto & Pittman, 2013; Manning, 2008). A dramaturgical approach provides different elements (e.g., stages and

scripts) for gaining a deeper understanding of the complex ways in which professionals engage with surveillance.

We develop a dramaturgical approach to surveillance in a context in which possibilities for surveillance of professionals' work increased after the introduction of a new communication technology. More specifically, we examine so-called personal online health communities (POHCs) that facilitate communication between healthcare professionals and their patients with Parkinson's disease. The initiators set up this secure online space, in which a patient can communicate with her or his locally dispersed healthcare professionals from different disciplinary backgrounds, with the goal to better include both patients and healthcare professionals in the care provision process (ParkinsonNet, 2012). POHCs open up possibilities for surveillance of professionals' work, because communication that used to take place one-on-one in the consultation room, or over phone or email with only the patient or a fellow healthcare professional, now has to be performed on the POHCs in front of a heterogeneous audience.

Our analysis shows that professionals use different elements of the theater, most prominently the front- and backstages, scripts, and the regulation of others' performances, to enact surveillance at the micro-level of interaction. Constructing a dramaturgical approach to surveillance allows us to argue that professionals can, to a certain extent, direct how surveillance enters their professional lives, in order to benefit their displays of professionalism. This dramaturgical approach allows us to cement a view of surveillance as enacted. With this term 'enactment', meaning a focus on actions and emergence (Cornelissen, 2004; Nayak & Chia, 2015), we study surveillance as practiced *in* daily work, rather than merely an influence *on* daily work.

We proceed as follows: we first develop our theoretical framing of professional surveillance in light of dramaturgical work. Thereafter, we discuss our empirical case and

methods for data collection and analysis. In the results section, we display the findings from an analysis of quotes from interviews with 13 healthcare professionals and from 377 posts obtained through long-term observations of their use of POHCs. In the final section, we position our findings in a broader theoretical context and discuss our contributions, practical implications, and avenues for future research.

Professional surveillance

Professional surveillance has been conceptualized as a form of power, drawing on a myriad of classic theories, such as Marx' capitalist labor process, Weber's bureaucracy, and Foucault's Panopticon (Foucault, 1979; Tucker, Marx, & Engels, 1978; Weber, 2005/1930). As scholars from different fields have shown, professional practices have become more visible and attempts have been made to translate them into procedural rules, protocols, and guidelines (Adler & Kwon, 2013; Fournier, 1999; Walshe, 2002). These guidelines open the door to auditing by the larger public, resulting in a loss of professional autonomy (Adler, Kwon, & Heckscher, 2008; Beddoe, 2010; Leung, 2008; Munro & Hatherly, 1993; Ramirez, 2013). Therefore, professionals become subject to surveillance by a heterogeneous group of fellow professionals as well as clients, creating 'sousveillance' (surveillance from below) (Dennis, 2008; Mann, Nolan, & Wellman, 2003) and 'surveillance assemblages' (interlinked networks of surveillance) (Bogard, 2006). With the introduction of new technologies, this surveillance has become easier and less time-consuming, creating opportunities for making work more transparent, accountable, and monitored (Dennis, 2008; Mann et al., 2003; Muzio et al., 2013; Petrakaki, Klecun, & Cornford, 2016; Vieira da Cunha, 2013).

Although these macro-level trends are well-documented, less is known about how they play out at the micro-level of daily work, on professionals' identities and ways of working (Dent & Whitehead, 2002). Hitherto, dealing with surveillance at the micro-level of interaction has been conceptualized in a number of ways, often by dividing responses to surveillance into

resistance and compliance (Knights & McCabe, 2000; Rosenthal, 2004; Sewell, 1998). However, responses to surveillance have also been understood as "dynamic" (Waring & Currie, 2009), "hybrid" (Noordegraaf, 2011), and "relational" or "co-produced" (Gleeson & Knights, 2006), indicating that professionals' behavior is more complex than resistance or compliance (Brivot & Gendron, 2011; Thomas & Davies, 2005). Of particular importance for moving beyond a dichotomous reactive view of surveillance is Labor Process Theory's notion of 'consent' (Burawoy, 1979) which describes an active participation in power structures that neither fits with mindless compliance nor subversive resistance (Sewell & Barker, 2006; Thompson & O'Doherty, 2009). Consent emphasizes how workers actively participate in, rather than merely react to surveillance. It is this active participation that provides an important foundation for an enactive perspective of surveillance that we further cement by developing a dramaturgical approach to surveillance.

Dramaturgical professional surveillance

To develop this dramaturgical approach to professional surveillance, we draw on Goffman (1959) who adopts elements of the theater to understand micro-level interactions between individuals in everyday life (Cornelissen, 2004; Dick, 2005; Knorr-Cetina & Bruegger, 2002; Patriotta & Spedale, 2011; Zhao, 2005). Dramaturgical literature, in essence, sees these interactions as performances in which individuals try to maintain order and manage impressions by making positive impressions and avoiding negative ones (Goffman, 1959; Lemert & Branaman, 1997). As such, impression management is about staging the performance of a 'self' that an audience watching the stage will accept as legitimate.

Surveillance, implicitly, forms an underlying aspect of dramaturgy: with an audience looking at a performance on stage, its watching eyes constitute surveillance, one that continuously informs the performer's performance. Scholars have alluded to the fact that Goffman's work might pose a valuable viewpoint for understanding surveillance and the

impression management that results from it (Brivot & Gendron, 2011; Collinson, 1999; Molstad, 1988; Reid, 2015; Vieira da Cunha, 2013). We extend this initial use of Goffman's work with regard to surveillance by building a new theoretical approach that adopts theatrical elements to understand professional surveillance to unleash the full potential of Goffman's work. More specifically, we use front- and backstages, scripts, and the regulation of others' performances that illuminate different aspects of surveillance.

Front- and backstages

In *The Presentation of Self in Everyday Life*, Goffman argues that some performances occur on a frontstage with a full audience present. Other performances, however, take place on backstages, where individuals are able to perform other versions of themselves, less bound by the strict rules of the frontstage. No longer being watched by a particular audience, the individual is not confined to socially desirable behaviors in relation to that audience. Even though Goffman talks about the presence of 'barriers' (1959, p. 106) between the front- and the backstage, other dramaturgical work has shown how these boundaries are, at times, unstable and how the front- and backstage can shift (Brivot & Gendron, 2011). Baralou and Tsoukas (2015) describe the stages as being relative to each other, where one can be on a frontstage that is simultaneously someone else's backstage. The audiences for different performances are, therefore, also subject to change, which can be useful for better understanding how these stages and audiences shift within professional surveillance.

Front- and backstages speak to transparency, a recurring theme in surveillance literature (Garsten & De Montoya, 2008; Johnson & Regan, 2014; Levay & Waks, 2009; Townley, 1993). The different stages can show how, through making certain things visible and hiding others, professionals decide what content is (in)appropriate for specific audiences. On the studied POHCs, all conversations take place in front of the entire heterogeneous audience of patient and healthcare professionals (i.e., the frontstage). One-on-one conversations (a former

backstage) are no longer possible when communicating through the technology. Previous studies have used Goffman to demonstrate the importance of backstages for the medical profession, showing that professionals sometimes discuss medical issues and prognoses with fellow professionals hidden from the view of patients (Greener, 2007; Lewin & Reeves, 2011). We build on this work to understand when professionals feel the need to move conversations to a backstage and how that connects with the watching eyes of the heterogeneous audience on the POHCs.

Scripts

Making information visible comes with a requirement that one is able to justify her or his actions. For this justification, criteria for judgment need to be available to ensure that professionals are accountable on them (Giddens, 1984). Accountability is another common theme in surveillance studies (McGivern & Ferlie, 2007; Munro & Hatherly, 1993; Ogden, Glaister, & Marginson, 2006). In the dramaturgical literature, accountability criteria are located in 'scripts'. When performing, performers make use of scripts to guide them through the performance as they contain all the "rights and duties attached to a given status" (Goffman, 1959, p. 16). Therefore, the script is crucial in knowing how to behave in certain interactions. While being watched by an audience, the performer can turn to the script to make sure that the impression she or he makes is managed correctly.

Professional scripts, in particular, shape and are shaped by individual professionals and constitute "the rules of signification, of power hierarchies and norms of his or her profession" (Hotho, 2008, p. 727). Through the introduction of a new technology to communicate, existing scripts for professional behavior might not be useful anymore. For example, what was once regarded as medically ethical behavior in terms of privacy and communication with or about a patient, could change through the introduction of the POHCs. Moreover, on the POHCs, professionals can be held accountable on the basis of different scripts used by a heterogeneous

audience (i.e., patients and fellow healthcare professionals simultaneously). The change in audience might result in the co-existence of multiple scripts, and the legitimacy of the performance might increasingly depend on the social status and resources professionals can draw on (Lemert & Branaman, 1997). In this article, we explore how professionals deal with (co-existing) scripts to deepen our understanding of professional surveillance.

Regulating performances

So far, we have used dramaturgical work to investigate how one performer (a professional) might reflect on her or his own performance in relation to an audience. However, as both dramaturgical and professional surveillance literature describe, performances and surveillance, respectively, also involve external regulation, through mutual monitoring. Monitoring, in the surveillance literature, describes how one individual can regulate the behavior of another (Rosenthal, 2004; Sewell, Barker, & Nyberg, 2012). Similarly, dramaturgical literature describes how performing involves other individuals, either fellow performers or audience members, who can regulate a performance (Goffman, 1959).

When a performance is flawed in the eyes of the audience or a fellow performer, consequences follow to ensure the recovery of a coherent performance (Kivisto & Pittman, 2013). On the one hand, this monitoring of each other's performances allows the audience to step in and redirect the performance. On the other hand, it allows fellow performers to interject when their own performance is threatened. Dramaturgical work has referred to these regulatory activities as protective and defensive measures respectively (Goffman, 1959, p. 212). Dealing with these threats can end up providing an opportunity for strengthening one's professionalism (Brown & Coupland, 2015).

Stepping in after the fact was the only possibility before the POHCs were introduced. As professionals were not present for conversations that took place in other consultation rooms, their only opportunity to regulate others' performances came up when they would, after the

fact, be told what was communicated during those separate conversations. On the POHCs, the opportunities for regulation are more immediately available. In this article, we use regulating of performances to understand how boundaries between professions become more apparent and might have to be monitored through performances.

Now that we have shown how we connect dramaturgical work to surveillance literature, we will enrich and demonstrate the worth of this dramaturgical approach to surveillance by examining it with the help of empirical data. In the next sections, we will describe our empirical context, our data collection and methods of data analysis.

METHODS

Case study context

In this article we examine personal online health communities (POHCs) set up on the website www.mijnzorgnet.nl in the Netherlands. Between 2011 and 2013, ParkinsonNet (an organization in the Netherlands attempting to increase the quality of care for patients with Parkinson's disease) conducted a pilot project, where over a hundred patients were supported in setting up an online community through the MijnZorgnet website. Multiple Parkinson's nurses were appointed to support the patients and their healthcare professionals in gaining access to the website and using the POHC. The Parkinson nurses approached patients who they thought would benefit from using the POHC, but the opposite also occurred, where the patient approached the appointed Parkinson nurse and asked to be included in the pilot. The POHCs were set up in such a way that the patient was the owner of the community and she or he decided which healthcare professionals became part of their POHC. The healthcare professionals received no remuneration for their participation in the project; only the four Parkinson nurses were financially compensated for their time through a grant obtained by ParkinsonNet from a governmental funding agency specialized in healthcare research. The content and use of the

POHCs was only visible to those who were invited to join (the patient, healthcare professionals, Parkinson nurses, and, as we will explain below, the first author of this article). To ensure the confidentially of the communities, ParkinsonNet (as the organizer behind the pilot project) did not have access to the content of the POHCs, although it did contact participants with a survey to gain anonymous insight into, and evaluate the success of, the project after it concluded.

The online community offers a number of options, among which starting a 'virtual meeting' and writing in a diary. Patients can give updates in their diary section and healthcare professionals can respond to those diary entries if necessary. Patients (and healthcare professionals) can start a virtual meeting if they think an issue requires an active discussion. The individual who starts the meeting can decide which of the other members within the POHC to invite to participate in the meeting. These invitees will receive an email alert of all entries within this meeting. However, those not invited to the meeting, can still read and participate in the conversations.

This pilot project was set up specifically for patients with Parkinson's disease. Parkinson's is a chronic and degenerative disease with which most patients are diagnosed at a later stage in their lives (Lees, Hardy, & Revesz, 2009). No cure exists, and because of the chronic nature of this disease, patients build a long-term relationship with their healthcare professionals, most of whom they see on a regular basis. Most patients see their neurologist (generally seen as the principal healthcare professional, because of her or his role in the initial diagnosis and medication prescriptions) once every six months. Neurologists can also direct patients to other healthcare professionals. A range of treatments is available, but physical therapists, speech therapists, occupational therapists, and dieticians are among the most commonly visited healthcare professionals. These healthcare professionals are not, in most cases, in regular contact with each other about a specific patient, and the pilot project is an

attempt to stimulate better involvement of these geographically dispersed healthcare professionals and the patient (ParkinsonNet, 2012).

Data collection

For this article, we performed in depth case studies of five online communities, where we interviewed healthcare professionals and observed them during a period of between 22 and 34 months (see Table 1 for an overview). We observed the online behavior of the five patients and the 19 healthcare professionals involved in their care provision, which led to a dataset of, in total, 377 written posts. Entrance to the five cases was obtained via semi-structured interviews with the patients (only patients have the ability to add others to their POHC, and we contacted them with the help of the Parkinson's nurse assigned to each region). We selected the five POHCs on the basis of the multiplicity of medical disciplines of the professionals involved, to allow for the best analysis of how surveillance enters healthcare professionals' daily work. After all, if only the neurologist is included in a patient's POHC, their situation would not be much different from the traditional context of the consultation room, in terms of the heterogeneity of the audience involved in the surveillance. In total, 19 different healthcare professionals were involved in the five POHCs (four professionals were involved with two or three POHCs in our sample), and they included neurologists, physical therapists, nurse practitioners, occupational therapists and rehabilitation specialists. In addition to the observations of the five POHCs, our dataset includes semi-structured interviews with 13 of these healthcare professionals. We contacted all 19 healthcare professionals involved in the POHCs but six of them declined to be interviewed because of time constraints. We did, however observe postings on the POHCs of all of the 19 healthcare professionals.

The first author (a white, middle class woman, at that time, in her mid-twenties) conducted the semi-structured interviews face-to-face, although in some cases a telephone interview was conducted when requested by the interviewee. The topic list focused on how

healthcare professionals experience the use of a POHC, what they think are the advantages and drawbacks; which subjects are useful to discuss online, and which are not; and in what cases they hesitate when posting messages online. During the conversations, the interviewer focused part of the interview on the increased visibility of communication. The interviewer explicitly asked the interviewees about their experiences regarding the watching eyes of others, although some healthcare professionals discussed this topic without explicit prompting by the interviewer. Face-to-face interviews lasted between 23 and 66 minutes, while the telephone interviews lasted between 15 and 27 minutes. All interviews were transcribed verbatim. To protect the privacy of healthcare professionals and patients, aliases were used to identify the respondents.

INSERT TABLE 1 ABOUT HERE

Data analysis

We analyzed our data using interpretive qualitative analysis. Accordingly, our epistemological and ontological assumptions are that social realities are constructed by the multiple meanings that research participants give to their own actions (Bryman, 2012; Schwandt, 2000). The role of the researcher is to interpret these meanings by going beyond the content of quotes and excerpts analyzing how research participants' language constitutes the framing of their position and their relationships with others. Furthermore, in interviews, research participants construct the social meanings in interaction with the researcher, which influences how and what a researcher writes about a subject (Alvesson, 2010). For example, the position of the interviewer as a junior female academic influenced her interviews with healthcare professionals of different hierarchical statuses, with high status professionals being more critical toward the interviewer's questions and lower status professionals more prone to elaborate on their answers and take

more time for the interview. In turn, this awareness of power dynamics influenced the analysis of surveillance, because it alerted us to the importance of the different hierarchical positions of healthcare professionals in our data.

Our analysis started with reading the interviews with healthcare professionals. In reading those, we noted how professionals were aware that others could see and possibly judge their communications. This realization led us to the concept of surveillance, which also connected to our interest in power processes in health innovations (such as POHCs). We coded passages that made some reference to how communication on the POHCs was affected by the heterogeneous audience present. We started coding these instances first with the general code of surveillance, and then tried to get a sense of which information professionals were (un)willing to share. During this initial coding, a general distinction came up, as professionals provided reasons for why conversations were (un)suitable for the patient versus why they were (un)suitable for fellow healthcare professionals.

Our second order coding was derived from our theoretical approach. In our linking of surveillance literature to the dramaturgical literature, we distinguished between different aspects of surveillance which also formed our second order codes. These aspects are front- and backstages (or, transparency), scripts (or, accountability), and regulation of others' performances (or, monitoring). While reading the interviews, therefore, we coded sections that were either discussing making communication transparent, being accountable for one's actions, and monitoring others' performances. In this coding, we were particularly interested in the argumentation professionals used for their activities.

After identifying the passages in the interviews that fit the above criteria, we moved our analysis to the observations of the POHCs. The content of the POHCs was also analyzed on the basis of the above mentioned three aspects, but required a different focus. On the POHCs, surveillance was rarely openly referenced; we could only observe the end product (i.e.,

what they actually wrote down) of the internal process of deciding how to engage with the heterogeneous audience on the POHCs. Therefore, the observations of the medical discussions on the POHCs allowed us to connect what was said during the interviews (about the internal decision-making process) to what was actually communicated on the POHCs. Therefore, the reasons and aspects identified in the interviews guided our analysis of the observation of the POHCs.

In our interpretive analysis, we used a number of lenses to go beyond the superficial layers of the excerpts. First, we looked at the use of words and sentence constructions; sentences including normative statements (e.g., 'should'), oppositions (e.g., 'but') or hesitations (e.g., 'might'). Second, we examined the tone of the excerpts (e.g., sarcastic or apologetic). Third, we critically examined the material consequences of what was said, such as excluding others from conversations. Such a focus on how professionals' use of language framed their own positions regarding surveillance enabled us to take a fine-grained approach to understanding how professionals engage with surveillance.

All interviews and postings on the POHCs were in Dutch. We conducted our analysis on the original Dutch text and translated the excerpts we used in this article to English at the last possible moment. In this translation we focused on containing the meaning and, when relevant, the phrasing used by the professionals. We prioritized containing the tone of the excerpts over the literal word-for-word translation of the text. Moreover, we copied punctuation (errors) observed on the POHCs.

RESULTS

Creating back and frontstages: transparency

The POHCs allow the communication between healthcare professionals and patients to become more accessible for all involved (ParkinsonNet, 2012). In other words, an important aspect of

the POHCs is creating more transparency. First, we discuss how professionals experience patients' presence in the audience to see healthcare professionals perform their daily work:

> *The advantage [of using a POHC] is that this isn't going behind the patient's back. Because you know, as a patient you can also say to the therapist […] just talk about it with the neurologist, but then he [the patient] doesn't know what has been discussed with the neurologist. And this way, at least he is aware of the information that is exchanged.* *Eric, neurologist - interview*

Eric describes that, in his experience, the POHC changed the communication with and about the patient. In the past, patients would sometimes ask one of their therapists (e.g., physical or occupational therapists) to initiate communication with him (as the neurologist). As Eric explains, this way the patient was not aware of the content of the conversation. He phrases this as "going behind the patient's back", invoking the image of talking about someone who is near, but nevertheless not included in the conversation. With the introduction of the POHCs, the conversations among professionals became accessible for the patient. Therefore, the transparency created by the POHCs brings communication from the back- to the frontstage.

Although Eric speaks to the advantages of transparency, there are also healthcare professionals who see downsides to the involvement of patients in every aspect of communication between healthcare professionals. The transparency of the POHCs has its limits, as a physical therapist describes:

> *The patient doesn't always have to be there when you discuss certain things, because it's a discussion on a medical level, so to speak. […] In that case, it's easier to just go back and forth about if it might be this or that. That might just work a bit easier. But the most important thing is that the patient gives consent for the discussion, and that you feed back the information.*
>
> *Matt, physical therapist - interview*

This excerpt indicates that healthcare professionals construct the 'ease' of communication as a criterion for deciding to exclude patients from conversations. Excluding the patient allows for 'going back and forth' about possible diagnoses, implying that these conversations are not suitable for patients, even though diagnosing forms an important part of the performance of their daily work. Through Matt's use of the words 'medical level', he positions the patient as not being on the right level to interpret these diagnostic conversations. In his words, conversations about possible diagnoses should be taken to the backstage instead (i.e., communication outside of the POHCs). Ultimately, Matt's performance of his work in terms of diagnosing "might" be easier on the backstage without the patient's presence in the audience, because "here the performer can relax; he can drop his front, forgo speaking his lines, and step out of character" (Goffman, 1959, p. 112). He explicitly mentions that after such conversations take place, information needs to be fed back to the patient, who is only able to see the frontstage (i.e., the POHC).

The presence of this backstage for medical conversations also became apparent in the observations of patients' POHCs. In the following excerpt, we see Katie, a neurologist, talking to a patient about a rash that he described to his healthcare professionals, which he thinks is a result of the skin patch he uses to receive his medication:

Postings on POHC 1

Katie, neurologist

We'll do some research on your question about the neupro patch. My colleague [Parkinson's nurse X1] will contact the manufacturer in the coming days. We just discussed it in our meeting. I hope the skin disorder hasn't gotten worse.

Patient 1

I went to the general practitioner yesterday with a letter to invite him to join the POHC. I showed him the spots and he thought it was a contact allergy.

Katie, neurologist

If the general practitioner thinks you're experiencing a contact allergy from the patches and it won't go away, then maybe we should switch to different medication after all. But then, I would like to see you again in the clinic

As Katie openly explains, she has communicated on a backstage with other healthcare professionals in a meeting, and uses the frontstage of the online community to relay the next steps of action. The patient, in the meantime, has also gone backstage to ask his general practitioner for advice. This general practitioner is not participating in the online community yet, however, through the patient, his opinion (that the patches are causing a contact allergy), becomes performed on the frontstage of the online community. Katie, in turn, acknowledges his diagnosis but argues that if they want to decide to change medication, the patient will have to come into the hospital to have a face-to-face meeting (backstage). This excerpt helps to construct a more nuanced interpretation of the concept of transparency on the POHCs; not all communication is made transparent on the POHCs. Rather, both healthcare professionals and patients have offline conversations with other healthcare professionals to ensure the presence of multiple points of view.

The transparency offered by the POHCs is not only difficult with an audience of patients. The healthcare professionals also comment on the difficulties that arise when communication between themselves and a patient becomes available for their fellow healthcare professionals. These difficulties become particularly pertinent when topics of a private nature are discussed on the POHCs. Parkinson's disease comes with a myriad of debilitating

symptoms, some of which are typically considered rather sensitive issues. Although these topics might be hard to address in the consultation room as well, the fact that everyone is able to read about them when discussed on POHCs, makes it more difficult for healthcare professionals to discuss such issues.

> *I think that private topics, sexual disorders, that people don't like to discuss that online. But if it concerns the evaluation of certain medication changes, for example. That they could discuss.* *Tim, neurologist - interview*

Tim describes how he believes patients might not like discussing issues that he constructs as "private" such as sexual disorders on the frontstage of the POHC. Even though all other audience members are professionals and could, therefore, be expected to be trained to discuss issues such as these, he constructs a barrier between appropriate and inappropriate topics to discuss. He positions topics such as changes to medication as less surrounded by feelings of shame and, therefore, more appropriate for discussing in the transparent environment of the POHC.

These excerpts show that, in the performance of daily work, professionals are aware that their audience contains both fellow professionals and patients. Professionals continually create new front- and backstages to ensure that through their performance of their daily work no information is made transparent that they construct as inappropriate for (part of) the audience on the POHCs. To manage their impressions as a professional, these healthcare professionals suggest the existence of two options: they can either limit discussions to appropriate content, or circumvent the communities altogether, and strike up a conversation with a fellow professional or a patient on the backstage of the POHCs (i.e., offline). Both options ensure that some of the medical conversations remain invisible to part of the audience. Although the POHCs were set up to make communication more transparent through eliminating the backstage, the way the healthcare professionals enact transparency results in a

reinvented backstage. It suggests that organizing such a backstage is a vital part of professionals' daily work and they talk openly about the existence of backstage, by communicating to patients that they have discussed the patient's condition in a separate conversation with fellow professionals. Therefore, when attempts are made to remove the backstage, professionals seem to find a way to bring it in again. Through these practices, the boundaries between front and back become blurred as professionals are more transparent about the process of deliberation but not necessarily about the content of these deliberations.

Use of scripts: accountability

When deciding what information and communication to make transparent, professionals use and construct scripts that prescribe appropriate communication. We have already seen examples of this with healthcare professionals discussing how medical conversations (based on medical scripts) are not appropriate for patients while performing on the frontstage of the POHCs. Below, we discuss an example of a Parkinson's nurse who draws on a script of professional conduct between patients and healthcare professionals:

> *This one lady said "you should just call me Betty". But then I don't do that on the POHC, you know. Yeah, I think, the neurologist can also see it in that case. And then I think, yeah, it wouldn't be really professional if I say "Hi Betty, how are you? How was bingo?" you know? No, I don't do that […] yeah but that's just because others are reading it as well. You just have to have some sort of a professional attitude. Not that you're not professional when you are in that situation, but here [POHC] you see it in black and white.*
>
> *Julie, Parkinson's nurse - interview*

Julie explains how, for her, there is a difference in the tone of offline conversations compared to online. Through a dramaturgical lens, we can interpret her behavior as impression

management when communicating on the POHCs. The script of professional conduct Julie uses, prescribes how informal she can be when addressing a patient. This script acts as a "means of getting an audience to understand a role" (Kivisto & Pittman, 2013, p. 275). In other words, performing according to this script ensures that the audience (consisting of a patient and fellow healthcare professionals) recognizes her as a 'professional'. As the quote continues, Julie seems especially concerned with impression management in relation to the neurologist. Whereas she allows herself to address her patient informally during offline conversations (Julie 'should' call her Betty), the frontstage of the POHCs changes the script on appropriate ways to talk to patients. The nurse's construction of professionalism (as constituted in relation to the neurologist) asks for more distance between patient and healthcare professional. Different scripts seem to exist around what professional behavior entails in terms of informal communication. Rather than going along with the patient's wish to be addressed in an informal way, this nurse prioritizes the neurologist as an audience member over the patient. She chooses to be accountable on the basis of a script of professional conduct she constructs in relation to the neurologist instead of in relation to the patient.

Not only the content, but also the attentiveness one displays through one's messages is a topic that professionals are accountable for when they communicate on the POHCs. Below we see three postings we observed on different POHCs where healthcare professionals explicitly refer to how they provide care while being part of a POHC.

Posting on POHC 4

[The patient initiated this conversation about how she had been doing. The Parkinson's nurse intervened in the conversation, telling the patient to actively invite the physical therapist for the 'virtual meeting' next time so that he'll get a notification. The patient answers that she though she did. The physical therapist then writes the following:]

Matt, physical therapist

I did receive a notification. But I just discussed this face-to-face [with the patient]. Next time, I'll just do it electronically. Of course, that's what we're supposed to do :-)

Posting on POHC 3

[The patient posted an additional question, after posting a question about a new therapy that was mentioned in the newspaper the day before. The rehabilitation specialist responds to that additional question as follows:]

Becky, rehabilitation specialist

To be honest, I still need to read that article. I'll do that first.

Posting on POHC 3

[The Parkinson's nurse started a conversation saying that she had to cancel an appointment last minute. The patient responded the next day, giving an update on how her other appointments had gone. The Parkinson's nurse responds 2.5 weeks later, starting her posting with the following:]

Tami, Parkinson's nurse

I am only seeing this message now… don't always get alerts for postings anymore. So must become more attentive myself!

In these excerpts, healthcare professionals are apologizing for different kinds of inattentiveness. They apologize for a backstage conversation or a lack of response, because

they either have not caught up with the newest developments in terms of research or because they missed the alert that notified them of a new post. Through these apologies, they position the POHCs as presenting a new expectation of timely and expert responses that are visible to all. These expectations indicate that the environment of the POHCs alters the scripts prescribing the "rights and duties" (Goffman, 1959, p. 16) of healthcare professionals. However, these scripts, through which they justify actions, are not uniform for everyone. Rather, multiple scripts coexist, as other healthcare professionals do not feel the same pressure to respond quickly:

> *[I: did you make any agreements on how long you can wait with responding?] No we don't have any agreements like that here [...] of course it would be nice to not take too long […] but a response within a couple of days is fine. […] But it's one of 40 or 50 emails that I get in a day. So that disappears very quickly from my mind and then I think "oh yeah I still need to do something with that email".*
>
> *Tim, neurologist - interview*
>
> *[talking about Patient 1:] if he needs to wait three days, maybe sometimes a week, for an answer, that might be very frustrating for him. If you think "well, there is a POHC, I can ask my neurologist questions at any given time". [I: and this is not possible in reality?] No. […] I just don't get around to it.*
>
> *Katie, neurologist - interview*

These two neurologists, who are both based at the same hospital, construct a different picture of the response times patients can expect from them compared to the healthcare professionals observed above. They seem less concerned with response time as a topic to be accountable on, as they cite the reality of time constraints. These different quotes construct the existence of multiple scripts that professionals feel accountable on when communicating on the POHCs. One of these is a script of technology, prescribing certain conventions around how to use the

possibilities for quick response times that the technology affords. The other script (used by the neurologists above) speaks to the high demands of their profession and the limited time they can spend on individual patients.

Regulating the performance of others: monitoring

So far, we have examined surveillance as a largely internal process focusing on professionals' responsibility for their own performances. On the POHCs, however, surveillance is also an interactive process where one can monitor another; by reading each other's messages and supplementing them where necessary. A physical therapist describes how such monitoring regulates the conversation a patient has with her or his healthcare professionals.

> *The explanation that the patient gives, they don't always know what is going on. […] And when medication is changed because of a particular reason [they say] "yeah, my medication has been changed". But why? "Well, I don't actually know". And some people can articulate this, but a number of them can't. And in that case, I like seeing […] what has been done, how did it go […] and how is going now. And that is easier than having to get all of the information from the patient. Because the patient only talks about how he feels. And what he thinks happened. [I: and that isn't always correct…?] No*
>
> *Shelby, physical therapist - interview*

According to Shelby (a physical therapist), reading how other healthcare professionals feel the patient is doing, allows for a more accurate description of the patient's health status, compared to getting the information from the patient (as was common before the introduction of the POHCs). Without direct contact, the professionals could not be sure if this was entirely correct information as the patient only talks about "what he thinks happened". Therefore, by broadening the audience for healthcare professional-patient interactions, the physical therapist

is better able to manage the information from other healthcare professionals. Fellow healthcare professionals in the audience can potentially interfere when the performance a patient gives is going wrong. If such regulating is necessary "poor members of the team, who are expressively inept, can be schooled or dropped from the performance" (Goffman, 1959, p. 112). 'Dropping' the patient from the performance by directly communicating with the other professionals could prevent the patient from making a mistake in relaying information from one healthcare professional to another. Below, we discuss an example of monitoring of the patient observed on her POHC.

Postings on POHC 3

Patient 3

My muscles are very sore from the exercises of sitting up straight and balancing on a big ball; could not get one foot in front of the other. Now there is some improvement in my backaches.… the quadriceps and the right foot only really hurt. This is probably muscle soreness and that is a good sign, right? Have been working on it for half a year already.

I'm also sitting lop-sided in this chair and every movement is one too many. So I'm keeping it short..

Brian, Parkinson's nurse

During my visit, I noticed that you were sitting incredibly lop-sided and that you also walk incredibly lop-sided (I'm not a real expert, but it seems to me that somehow you tilt your hip extremely inwards?)

I don't recognize this stance from before. It has been an extreme change in the last 2? months.

Hopefully, someone in your team has a solution.

Tyra, physical therapist

I just read Brian's message. Would it be useful to make an appointment again after all? I would like to look at this with you.

Brian (a nurse practitioner) picks up on some of the hints Pam (a patient) has left about her ability to sit straight. He communicates his worries about her ability to walk straight and actively asks the other healthcare professionals to present their thoughts on this problem (something the patient has not asked for, as she focuses on the aches she experiences). Through this monitoring, the nurse practitioner supplements the patient's performance, by emphasizing the severity of her symptoms. His interjection ensures that the patient's problems are noticed even when she does not emphasize them as much. Tyra's (a physical therapist) response confirms the worry of the nurse practitioner about the patient's symptoms, as she suggests it could be useful to make an appointment outside of the POHC, bringing the rest of this conversation to the backstage of the therapist's consultation room. We also see Brian acknowledging that he is not an expert in this area. By doing this, he establishes the other healthcare professionals in the audience as the expert performers with regard to this subject, bringing them on the frontstage with him. Acknowledgement of professional expertise becomes more apparent in the next paragraphs, where we discuss the monitoring and regulation of the performance of fellow healthcare professionals.

Similar to our analysis of transparency and accountability, we see that professionals do not only regulate performances of patient performers but also of fellow professionals performing on stage. As we noted earlier, healthcare professionals' impression management revolves around a script of professionalism, which they perform on stage. In this performance they display their disciplinary expertise. We analyze an excerpt from an interview with Jason (an occupational therapist) who discusses the importance of his disciplinary expertise in the treatment of patients. Patients seeing an occupational therapist often look for adjustments to

their homes or workplaces to make their day-to-day life easier. As the occupational therapist describes, although he is responsible for making such adjustments, the neurologist is also often involved in suggesting certain adjustments to be made.

> *Neurologists also discuss adjustments and measurements and then he [the neurologist] says "that might be a good solution". And then I visit the patient and think "that's really not a good solution". Then I just put it on the POHC, like "I've tried this and this and it didn't work because of such and such". And then the neurologist knows this. But you also have to be a bit careful with how you communicate these things to patients, because 'what the doctor says must be true'. [pretending to be the patient:] "But, actually, my neurologist thinks this is a really good idea". Then I just say "yeah but if he takes care of the medication, then I stick to my disciplinary background".* *Jason, occupational therapist - interview*

This quote constructs the introduction of POHCs as making it easier to monitor and regulate the transgression of professional boundaries: Jason 'just' writes on the POHC that he has tried a solution offered by the neurologist, but that it did not work. That direct line with the neurologist is positioned as an advantage of the POHC for Jason. At the same time, emphasized by the word 'but', professionals are also careful about the phrasing of such messages. In performing his daily work, Jason is aware that the patient might disagree with his proposed solution (i.e., the patient uses another script) and patients might position him in different role than he wants to play. As Jason suggests, the patient is used to the neurologist always being right, so she or he might prefer the neurologist's word to that of the therapist's. He rather sarcastically comments that 'what the doctor says must be true', suggesting a sense of irritation toward the idea that his discipline is ranked lower and his opinion is valued less than the neurologist's. However, because of the POHC, Jason is now able to regulate the performance

of both the patient and the neurologist. As the patient is also in the audience on the POHC, Jason needs to (and can) perform his daily work and display his disciplinary expertise to both parties at the same time. He is able to 'expose' the neurologist as less of an expert in the area of occupational therapy than Jason is, by indicating that his solution did not work.

Next to the allied healthcare professionals, some medical specialists (in this example, a rehabilitation specialist) also display an awareness of the boundaries between disciplines.

> *Imagine that they [patients] have certain symptoms and I think the physical therapist should give a certain type of treatment. In that case I think I should communicate this to the physical therapist first […] because if I would post on the community "well I think your physical therapist should do this and that…" That's not a decent thing to do. That's a collegial code that you adhere to. […] It's great that everything is now visible for everyone, but it also means that some things are not possible and that you should be aware of that.*
>
> *Becky, Rehabilitation specialist - interview*

Drawing on a script of professionalism (a "collegial code"), Becky argues that it is not "decent" to discredit a fellow professional's work in front of the patient. Using the word 'should', she emphasizes the existence of (unwritten) norms (i.e., scripts) around how you approach disciplinary boundaries in a collegial setting. When we compare the responses of Jason (the occupational therapist) and Becky (the rehabilitation specialist) we see that they are both aware of the fact that disciplinary autonomy and expertise exist and should be handled carefully. Notably, Jason talks about these disciplinary differences from the viewpoint of monitoring his own performance. Becky, on the other hand, discusses it from the viewpoint of monitoring someone else's performance, constructing a hierarchical difference in whose performance needs regulation on the frontstage and with what goal. The rehabilitation specialist, similar to the neurologist, is part of a group of specialists with a higher number of years of formal

education than the allied healthcare professionals (the group Jason, the occupational therapist, belongs to). The allied healthcare professional fears a transgression into his territory where the specialist is not confronted with similar issues, and instead has to be careful not to embarrass someone in a lower hierarchical position. Dramaturgical literature refers to this as 'defensive´ and 'protective' practices, respectively (Goffman, 1959, p. 212). These defensive practices are used by professionals when their own performance on the frontstage is threatened, whereas protective practices are used by the audience or fellow performers to save the performance occurring on stage. These practices, and the different use of them by different professionals, are an important way through which healthcare professionals enact monitoring.

DISCUSSION

Point of departure for this study was the development of a dramaturgical approach to professional surveillance, by examining how professionals engage with surveillance in their daily work. Professional surveillance has intensified and is increasingly conducted in new configurations such as networks or by clients and other non-professionals (Adler & Kwon, 2013; Bogard, 2006; Mann et al., 2003). Existing research gives initial insights into individuals' responses to surveillance in their daily work (Brivot & Gendron, 2011; Gleeson & Knights, 2006; Iedema et al., 2006; Noordegraaf, 2011; Rosenthal, 2004). Whereas reactive responses such as resistance and compliance have dominated surveillance studies, there is also attention for active participation in power structures, as, for instance, emphasized in the notion of 'consent' (Burawoy, 1979; Thompson & O'Doherty, 2009). With this article, we move from this reactive perspective and use the idea of active participation as a foundation to build an enactive perspective of surveillance. We argue that our dramaturgical approach draws attention to professionals' micro-level enactment of surveillance, which shows that surveillance is not external to one's professionalism, but constitutes an integral part of it, as we will discuss in more depth below.

The analysis shows the interrelations between surveillance and elements of the theater, looking at transparency on various stages, script-based accountability and monitoring through regulating others' performances. On the frontstage (the POHC), transparency exists as performances are played out in front of an audience. Around the frontstage, multiple backstages (offline conversations) exist where performers hide performances from different audiences. Professionals manage the watching eyes of specific audiences through playing with the different stages. Goffman (1959) suggests that front- and backstages should always be understood in reference to a particular performance. Although we have depicted the POHC as a frontstage, the backstage activity that takes place (for example, a neurologist discussing diagnoses with his team of colleagues) can be regarded as another frontstage (if you take the point of view of the neurologist or his colleagues). Our analysis thus shows that one performer's backstage can simultaneously be a frontstage for certain audience members or fellow performers. Furthermore, eliminating the backstage (creating total transparency) is often not possible as professionals find a way to organize the backstage in again (Johnson & Regan, 2014; Van den Brink, Benschop, & Jansen, 2010). Our analysis demonstrates that professionals mainly create this backstage to make the *content* of conversations invisible, for example, to allow for more efficient communication on a 'medical level'. However, these professionals simultaneously make the *process* transparent, indicating that backstage communication takes place without revealing its contents. This finding of the difference between content and process transparency might be embedded in or even prescribed by medical ethics (a form of a professional script). In these ethics, privacy and handling information in a sensitive manner remain important values while involving patients in the process of care is becoming increasingly important (Car & Sheikh, 2004).

Dramaturgical scripts provided a basis for accountability, a common theme in professional surveillance literature (McGivern & Ferlie, 2007). The rules and regulations, and

the (speaking) lines that are (implicitly) present in scripts allow professionals to be judged by the members of the audience. As our analysis suggests, multiple scripts can exist at the same time, especially as professionals have only recently started using new technology and need to adjust to the eyes of a heterogeneous audience. Being accountable in front of a heterogeneous audience requires improvising and changing existing scripts, which is not easily done (Greener, 2007; Ramirez, 2013). Dealing with conflicting scripts plays a larger role in surveillance and impression management than hitherto acknowledged, and forms an important way in which professionals enact surveillance beyond compliance or resistance.

In literature on surveillance, monitoring is often positioned as revealing a dark side of organizations, zooming in on the negative consequences for professionals who will be judged on their faults (Ball, 2010; Brivot & Gendron, 2011; Knights & McCabe, 2000). Such a focus is connected to a recent surge of articles in organizational literature on the (unquestionably important) 'dark sides' of organizations (e.g., Skinner, Dietz, & Weibel, 2014; Willmott, 2013). However, our dramaturgical approach allows us to illuminate a 'brighter side' of the monitoring and regulating of performers/professionals. We can see how professionals get a stage on which to display their professionalism, and on which they can monitor transgressions of their professional boundaries. To some extent, this echoes Waring and Curie's (2009) conclusion that changes to professions can sometimes be used or converted to secure legitimacy. Moreover, referencing Goffman, others have shown that repeatedly watching each other's daily work, for example in operating rooms, can contribute to smoother organizing processes (Riley & Manias, 2005). Therefore, our study contributes the idea that monitoring (and surveillance in general), seen through a dramaturgical lens, can become a resource for professionals, rather than only a liability.

Bringing these aspects together in one framework that reconceptualizes surveillance, enables us to answer our research question of how professionals engage with surveillance in

their daily work. We show how professionals create backstages, use different scripts for their interactions with different audiences, and defend or protect performances to manage professional impressions. Thus, they engage in different activities that make surveillance an integral part of their daily work and their sense of professionalism. For example, as the Parkinson's nurse is performing on the frontstage, she reconsiders the scripts that are used for establishing her professionalism and, on the backstage, she hides more informal behavior. This is an active process in which some audience members are prioritized over others. The fact that the Parkinson's nurse is more concerned with displaying her professionalism in relation to the neurologist compared to the patient is an example of enacting the watching eyes of a heterogeneous audience. Professionals enact surveillance as part of their professionalism, as they are aware of the possibilities for surveillance and decide how they can engage with this surveillance in such a way that it improves their daily work and the impressions they make. As surveillance becomes a part of professionals' daily work (they need to reflect on how they come across to a heterogeneous audience), professionals also become part of and drive the surveillance possible in the POHC (by deciding what is visible, how that is judged and how performances can be regulated). As such, our dramaturgical approach, focusing on micro-level interactions, has further cemented an enactive perspective on surveillance

Enacting surveillance, enacting power

This dramaturgical reconceptualization of surveillance as enacted shows the ways in which different actors influence their own and each other's performances, but a deeper analysis of power within this dramaturgical approach is warranted, especially with regard to how surveillance becomes an integral part of a sense of professionalism. Surveillance has been previously linked to power by, for example, focusing on professionals avoiding, defying and manipulating surveillance (Sewell, 1998; Shapiro & Matson, 2008). Some authors emphasize that professionals, in reaction to this surveillance, exercise agency in an attempt to maintain

their autonomy and position of authority (Gleeson & Knights, 2006; Levay & Waks, 2009). We take our analysis of power one step further through our dramaturgical approach that zooms in on and highlights how surveillance is enacted as a form of power at the micro-level of interaction. Therefore, we can show in more depth how enacting surveillance enacts power, and how hierarchies are played with. To make these points, we return to the theatrical metaphor and employ the dramaturgical elements of audience placement and lead and supporting roles.

In the theater, an important aspect is the placement of audience members, where seats are available further from and closer to the frontstage. We bring this idea of placement of audience members as an extension to Goffman's work to show how it links to surveillance as a form of power in multiple ways. First, for the audience members, their seat affects the (in)visibility of the performance. Going back to transparency, we have seen that some audience members got to see more than others. Those audience members who were given the front row seats had the best view, revealing the power processes involved in the theme of transparency. Second, for the performers, the placement of audience members affects whom they can see most clearly, as it shows whom professionals feel accountable to. Our analysis shows that, especially for lower ranked professionals, other professionals (in particular the higher ranked ones) are on the first row; these professionals are the ones for which the performers on stage are trying the hardest to put on a good performance, displaying their professional expertise. Back seats are much less visible to the performers on stage, suggesting that professionals behave less accountable to audience members in back seats and are less concerned with them watching their performance. This division reflects the importance of impression management when performances are subject to subordination and insecurity (Collinson, 1999).

The placement of audience members works differently for higher ranked professionals. In their discussion of what to make (in)visible they seem to position the patients on the first rows. Higher ranked healthcare professionals might have an easier time assigning the best seats

to patients, because their professional expertise is not as much a topic of debate as it is for lower ranked professionals. They can, as it were, 'afford' to prioritize the patient over their fellow professionals, as their professional identity is not in the same way at stake in relation to the other professionals present. Expertise of higher ranked professionals seems to be self-evident from the longer years of training and status assigned to their discipline (Dent & Whitehead, 2002). Although the evidence in our data is not conclusive, it does suggest that being watched by a heterogeneous audience might pose a bigger risk to one's professional status for lower ranked professionals than for higher ranked.

At the same time, lower ranked professionals can also gain the most from performing in front of a heterogeneous audience as we can see through the second metaphor drawn from the theater; the aspect of lead and supporting roles. The use of the POHCs makes it visible who leads and who follows in a performance. Some professionals are given the lead roles over others by the performer(s) on stage. See, for example, the occupational therapist's discussion of the patient thinking that the neurologist knows best, where he himself was assigned a supporting role. In the assignment of lead and supporting roles, hierarchies between different medical disciplines are acted out on stage. As multiple roles are available to individuals, performers sometimes have the flexibility to play with and switch roles (Greener, 2007). Using the concept of lead and supporting roles to understand surveillance, we note that monitoring allows professionals to change who leads and who supports. The therapist was able to assign himself the lead role through regulating the performances of the patient and the neurologist when the neurologist encroached on his disciplinary boundaries. With this regulation, he moved the neurologist to a supporting role.

These examples show that linking the themes of surveillance to dramaturgical elements adds to our understanding of surveillance as a form of power. Our developed framework shows that by enacting surveillance, power is also enacted. Such an enactive view of power brings to

the foreground the multiple ways professional hierarchies are played with and performed through daily work, and departs from seeing professional hierarchies as a cause for or effect of surveillance.

IMPLICATIONS AND FUTURE RESEARCH

To end this article, we move on from our theoretical contribution and discuss the practical implications of the framework. The surveillance of medical professionals exists parallel to discussions about patient-centered care provision. These discussions advocate a more prominent role for patients in medical decision-making, requiring more openness and transparency from the healthcare professionals (Berwick, 2009). Linking our discussion of professional surveillance to patient-centered care, suggests that the total transparency and accountability expected in patient-centered care is hard to achieve because of the management of impressions done within the enactment of surveillance. As long as healthcare professionals associate certain scripts to their professional status (such as those about medical deliberations and the formality of tone of conversations), healthcare professionals will try to achieve and manage a particular impression in front of their audience. The heterogenization of the audience (an important aspect in recent calls for integrated care (Kodner & Spreeuwenberg, 2002)) makes this process of impression management even more difficult. Professionals who are attempting to provide more patient-centered care should critically reflect on the limits of this ideal in terms of the professional identity that they construct for themselves.

Furthermore, we would like to comment on possible avenues for future research. First, we note that patients did not gain a central role in our analysis. We purposefully choose to focus on surveillance of professionals because they underwent the greatest transition, in terms of surveillance, through the introduction of the new technology (they were not used to being able to be judged by different parties, whereas patients were already subjected to watching eyes of their multiple healthcare professionals). However, patients might also struggle with the

question of what information to post when all healthcare professionals will be able to read it at the same time. For example, patients might phrase their experiences with and opinions about medication changes differently to their neurologist compared to their physical therapist. Therefore, it would be interesting for future research to include these perspectives in an examination that looks at how patients (or, more generally, clients or customers) can enact surveillance, and how this might differ from professionals. Second, the management of technological innovations such as the POHCs warrants further examination. Previous research on (healthcare) technologies, typically based in the Socio-technical Systems or Information Systems fields within Organization Studies, have commented on the influence of the initiators of technology on the adoption and use, showing how pilot committees oversee and influence the process of technology implementation (Galliers & Leidner, 2014; Winter, Berente, Howison, & Butler, 2014). These perspectives could provide an additional viewpoint for future research to understand the surveillance on POHCs, zooming out to the larger management of such innovations.

We believe that the insights we developed may inspire research in other organizational contexts. Although our empirical analysis is specific to the context of healthcare provision, we argue that it speaks to more general processes of the intensification of watching eyes on professionals' work (Adler & Kwon, 2013) and organizing through network structures (Oberg & Walgenbach, 2008). In line with a discourse of co-creating services and products, other sectors are also implementing similar network structures, such as online brand communities, where multiple audiences are brought together (Harryson, Dudkowski, & Stern, 2008; Wiertz & de Ruyter, 2007; Wood & Ball, 2013). In these contexts, whether online or offline and whether inter- or intra-organizational, watching eyes of others will force organizational members to engage with increased surveillance. In these contexts, similar to the POHCs, what

information is made transparent, what individuals are accountable for, and what monitoring takes place will play out within the interactions between the different actors.

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Personal Online Health Community	Healthcare professionals	Observation	Length observation in months	Number of posts	Interview	Length of interview in minutes
POHC Patient 1		X	22	13		
	Katie, neurologist	X	22		X	23
	Julie, Parkinson's nurse	X	22		X	31
	X1, Parkinson's nurse	X	22		-	-
POHC Patient 2		X	34	60		
	Tim, neurologist	X	34		X	24
	Julie, Parkinson's nurse	X	34		X	31

	X2, physical therapist	X	34		X	26
	X3, Parkinson's nurse	X	34		-	-
	X4, general practitioner	X	34		-	-
	X5, physical therapist	X	34		-	-
POHC Patient 3		X	33	167		
	Eric, neurologist	X	33		X	54
	Brian, Parkinson's nurse	X	33		X	40
	Tami, Parkinson's nurse	X	33		X	66
	Becky, rehab. specialist	X	33		X	39
	Jason, occup. therapist	X	33		X	47
	Tyra, physical therapist	X	33		-	-
POHC Patient 4		X	28	69		
	Eric, neurologist	X	28		X	54

	Brian, Parkinson's nurse	X	28		X	40
	Tami, Parkinson's nurse	X	28		X	66
	Matt, physical therapist	X	28		X	27
POHC Patient 5		X	32	68		
	Eric, neurologist	X	32		X	54
	Brian, Parkinson's nurse	X	32		X	40
	Tami, Parkinson's nurse	X	32		X	66
	Shelby, phys. therapist	X	32		X	19
	X6, general practitioner	X	32		X	23
	X7, Parkinson's nurse	X	32		X	15
	X8, occup. therapist	X	32		-	-
Total		19 healthcare professionals, 4 in	Between 22 and 34 months	377 posts	13 healthcare professi	Between 15 and 66 minutes

		multiple POHCs			onals, 4 in multiple POHCs	

Table 1. Table of interviewees