A REFLECTION ON THE EVOLUTION OF RELATIONAL DYNAMICS IN NEW SYSTEMS OF GOVERNANCE APPLIED TO THE HEALTH SECTOR

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Abstract

This research paper is concerned with the development of relational dynamics in new governing systems in the health sector. Changes brought about in this domain in decision and management structure lead to a reconsideration of relations between the different players in the system, in particular in terms of power and operational approach. This article uses a case study to analyze this new reality and shows how these developments can be sources of value creation and vehicles of a cooperative, productive approach. This article intends to show the interest and scope of the cognitive governing approach applied to the hospital sector. To this aim, the research has three objectives to provoke reflection and discussion: to investigate conflicts between health and administrative staff; to understand how they come about; and finally to determine the actions that enable the management of these conflicts, with a view to establishing a cooperation of creative value and sense between the medical and administrative domains.

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1. Context of the research

1.1 The general setting: principles and defining cognitive governance

Cognitive theories of governance have been developed and improved by many authors (Aoki, 2000 ; O'Sullivan, 2000 ; Charreaux, 2005). The cognitive approach is thus in keeping with a procedural logic that leads to value creation. Cognitive theories of governance give particular attention to the notion of cognitive conflicts, which are not to be confused with conflicts of interest, as considered by the shareholder theories of governance. While conflicts of interest are linked to the division of income, cognitive conflicts result more fundamentally from a difference in cognitive or axiological orientation (to do with values), in other words, a different representation of the world, as the one specified by Charreaux (2002). These conflicts appear particularly in social interactions within a decision-making group of people. Charreaux (2002) states that these cognitive conflicts "*take place when the strategic relevance of investment opportunities is being constructed and evaluated. Directors, administrators or significant shareholders can make incompatible propositions, or disagree when it comes to assessing the industrial viability of a project based on the same information because they do not share the same cognitive models".* (ibidem, p. 30) According to the author, value conflicts go well beyond questions of interests or cognitive models, in that they can guide preoccupied directors' decisions to preserve, for example, ecological risk

principles or principles of equity. The cognitive approach is concerned with issues of cognitive conflicts in terms of collective collaboration and value creation. Charreaux (2002) explains that while it is preferable to reduce conflicts of interest – a source of loss in efficiency, it is entirely otherwise as regards cognitive conflicts. Innovation, or even basic adaptation, is favoured by the joint existence of different cognitive systems.

Alongside the cognitive and value conflicts that form part of company governance, other authors have taken an interest in the notion of socio-cognitive conflicts anchored more in a sociological approach (Moscovici and Doise, 1992). These conflicts arise when different ideas or incompatible options are suggested in a group before making a choice. This conflict qualifies as social in that each individual must defend his position in front of the other members of the group. The decision process within the group will be all the more complex depending on how diverse the opinions are among those involved and how much is at stake. This applies even more so if the relations are informal; if they are governed by a low number of rules; and if the members in a minority are more inclined to interact with each other (Moscovici et Doise, 1992). In this perspective, and following the example of Charreaux (2002), the existence of divergent propositions can favour the creation of innovative solutions. In this way, socio-cognitive conflicts seem *a priori* beneficial for the creation and exchange of cognitive resources. However, as Stevenot-Guéry (2007, p. 158) explains, in a study conducted on capital investment and publication issues for directors, socio-cognitive conflicts appear in practice to be "difficult to regulate and lead, through lack of governing efficiency, to impasses and tensions that threaten the very foundations of cooperation."

1.2 The field of the study: new hospital governance and the evolution of the powers that this entails

In the French context, the term *gouvernance hospitalière* - hospital governance, often refers to decree n°2005-406, passed on the 2nd May 2005, which imposed a reorganisation or restructuring of hospitals as 'activity clusters', at the latest by December 31st, 2006. The boards of directors of hospitals thus had to discuss in particular the setting up of these clusters (length of terms of office, internal contract and profit sharing policy, performance evaluation criteria) and their governing bodies (representing the electoral colleges, ballot terms, conditions of functioning and organization). The objective of this reform was firstly to strengthen coordination between the administrative and medical bodies and secondly to increase the medical bodies' involvement and responsibility with regard to the contractual management of the hospitals via the clusters.

The new governance project integrated into the 2007 Hospital Plan responds to the need to combat the rigidity and barriers that are a hindrance to the functioning of hospitals (Vincent, 2005). The aim is to involve doctors in the management of the health institutions, as well as carrying out an audit and evaluation of their activities. In order to do this, the 2007 Hospital Plan specified two reforms: the decision structure reform and the internal contract reform.

In principle, health institutions must have two co-existing roles, each with different practices and values: on one hand the health staff must receive, take care of, and console the suffering; and on the other hand the management has to deal with the finance side of things, the accounts, etc. They have distinctly different values. The role of the health staff engenders a feeling of reservation towards profitability. Conversely, for the administrator, profitability is constantly being measured in relation to the resources being used. That said, both roles complement each other in that both make resources available that are necessary for each to function. This complementarity was minimal up to relatively recently (Dumond, 2003).

Methodology

The approach taken focuses on the study of one case in particular: a private non-profit organisation which agreed to be a Participant in the French Public Hospital Service (PSPH). The case in question is that of a PSPH clinic (referred to henceforth as clinic A). A PSPH clinic has the peculiarity of being a private but non-profit establishment. This kind of hospital appeared to be a favourable field for investigation for two reasons. Firstly, it is a field not yet delved into by research specifically focussed on the study of hospital governance. Secondly, the PSPH status is distinctive in that it is managed by the Management Committee, 'relatively' independent of the political power – in clinic A's case, the financing took place via pension fund schemes. The Management Committee appoints the director of the clinic and is in charge of legal matters. In contrast to public hospitals, this committee has real power, with sufficient freedom to exercise it.

Three main sources of data were gathered for this research. Fifty five interviews, each lasting an hour and a half, were conducted following an interview schedule. Fourteen internal documents were also consulted, (including PSPH statuses, clinic internal regulations, write-ups of executive meetings, the annual report) and sixteen external documents (including the legal ruling regarding health institutions, the circular pertaining to the establishment of the new hospital governance

system, the guide available to health institutions to examine their own management practices, etc.). Finally, the non-participant observation completed the gathering of data.

2. Analysis of the case

2.1 Case description

The example studied is a geriatric-oriented clinic which welcomes patients aged sixty and over, working and retired, and offers full hospital services with 24 hour care. The clinic is composed of 325 professionals.

The authority with the real power within the clinic is the Management Committee, followed by the Director-General. This non-profit organisation is therefore administered by a Management Committee, composed of sixteen members elected for a four year term by the General Assembly members. The majority of the latter are pension funds administrators who were involved in the creation of the clinic and its funding. The Management Committee is the equivalent of a Governing Body and has voting rights. It nominates a President, a Vice-President, a Secretary and a Treasurer for a two-year period. The Management Committee meets at least once every six months or when required, at the request of the President or the majority of its members. The Management Committee has extensive powers to manage and administer the association. Notably, they appoint and dismiss all clinical staff, set the salaries and decide on the required qualifications. They collect all funds owed to the clinic, ensure that all receipts are properly recorded, control and manage expenditure in line with the budgetary provisions and close the accounts which must then be submitted to the General Assembly. The President of the Management Committee also appoints the clinic's Director-General.

The management of the clinic (Director-General and Assistant Director-General) is at the centre of operations and reports back to the Management Committee. The President of the Management Committee and the Director-General of the Clinic meet in a more or less informal manner.

The role of the director is to manage the clinic for and in agreement with the Management Committee (or Board of Directors). He is responsible or co-responsible legally, in that the President of the Management Committee also bears responsibility for this. The Director is answerable to the Board of Directors for the smooth operation of the establishment and for its financial and social health.

2.2. Conflict identification and analysis

The clinic found itself faced with an obligation, to convert to T2A (an activity-based funding scheme introduced to the French Hospital System with the 2007 Hospital Plan), and an option – to change its governance. The clinic decided not to create an executive committee. The explanations given for their decision are twofold: the over-restrictive nature of the new governance and the uselessness of the interactive equipment when compared with the existing technical equipment in the clinic. Similarly, the decision not to set up activity clusters as defined by the 2005 2nd May ruling was a deliberate choice by the clinic.

Regarding the implementation of the T2A funding scheme, this was a positive step for the management as it obliged doctors to become more involved in financial concerns. While the management welcomes the scheme, doctors consider that its implementation is far too complex. Firstly, it asks them to carry out administrative work in conjunction with a precise formalization of their activities. In their opinion this procedure does not coincide well with their professional culture. The doctors feel that they are now being asked to become "accountant-minded" in order to combine economics and patient care, an apparently "impossible combination". The results of the hospitals' exercises are in fact henceforth subject to the value given to the activity or treatment. According to the doctors, it is no longer the patient that is taken into consideration but the effect of the patient's pathology on the budget.

Consequently, the conflicts between management and doctors became serious on account of their different roles and priorities. Management started to complain that doctors were not respecting any of the procedures; the activity reports were illegible, the pathology codes were often omitted etc. The administrative staff worked harder to gather the missing medical information from the doctors.

Furthermore, the number of meetings increased and started to become more concerned with good management and activity planning. These meetings were periodic evaluations of the proper use of the available resources (staff, material, time management) which put doctors in a contractual system in terms of defined health objectives. This measure seemed to offend a large portion of the doctors who saw these decisions as a complete failure to understand the specificity of their work, which demands on one hand autonomy in their judgements and decision-making and on the other hand a very particular time management system which oscillated between reflection and action / detachment and urgency.

Paradoxically, the doctors also criticised the fact that they were consulted less and less about

decisions that they considered fundamental, particularly the recruitment or conversely the dismissal of a member of the care team. Previously, they had the right to meet the candidates. Management no longer consulted them and imposed their choice of staff on the doctors. The doctors felt the need to clearly protect their individual decision-making and areas of action. Consequently, management's intervention in the recruitment and dismissal of health staff became a particularly sensitive issue for them.

In June 2007, management and the Management Committee met and outlined the non-compliance of actions taken to achieve the intended objectives: the administrative delays, no proposals for new medical projects, necessary for the clinic's reputation and the increasing number of conflicts between administrative and medical staff. The conflicts were particularly related to the perceived devaluation of the role of a doctor, the loss of their margin for manoeuvre in the daily management of activities and the lack of influence that doctors had on the recruitment process.

2.3 In search of another route: towards cooperation

In July 2007, faced with this inertia and the environmental pressures, the management and the Management Committee invited the doctors to meet with them to begin a consultation process to re-launch the clinic's activities. The three parties together decided to propose new solutions, based on areas of collaboration between doctors and management. Since July 2007, the management of the clinic plan monthly meetings between the clinics' doctors and management. These meetings try to ensure open exchanges and close and on-going collaboration between doctors and the management. This initiative is particularly appreciated by doctors as the meetings are not too frequent.

The organisation of these meetings was a decision made by the clinic, not an obligatory ruling. Management voluntarily initiated these meetings in order to increase the number of meetings with the healthcare personnel but also to provide regular updates on new regulations, strategic action plans etc. These meetings called 'management meetings" (administrative managers and doctors) come from a willingness to have a clear and shared policy promoting and taking into account the interests of doctors, management and patients. All the points tabled are debated, discussed and decisions are generally made by majority rule.

If agreement cannot be reached, the Chief Executive has the deciding vote. The meeting begins with administrative items, the monthly agenda, training offered to staff and communications. There then follows an agenda item relating to the "work" in progress in the clinic (particularly the implementation of the 2007 Hospital Plan). Following this, there is an agenda item on quality (for example, the rewriting of the client questionnaire, the implementation of new quality procedures or the use of new medical software). During each meeting, a new regulation to be implemented in the clinic is discussed. There is an open debate with all members on each point in order to propose and create an action plan. This structured and equal collaboration allows for items to be prioritised, for compromise and for information exchanges. In March 2008, during one of these meetings, the Head of the Medical Team gave details of a request by one of the clinic doctors: for the funding of a new technique for the treatment of complex geriatric wounds. This medical project was subsequently submitted to management at the initiative of the doctors.

In terms of discussions and knowledge sharing, management and doctors' concerns have ultimately converged. Progressively, doctors and the Director-General have realised that they share the same concerns: to have the project accepted at the highest level of the clinic governance, the Management Committee. By proceeding in this way, they created a common interest, they understand and accept each other's concerns. The creation of a space for dialogue, exchange and a space to build projects and also the concrete implementation of a unifying project has facilitated cooperation between the medical and administrative teams. This renewed dialogue has facilitated the better understanding/explanation of the challenges associated with the T2A funding scheme and in changing the terms of the debate, from a purely financial argument to an issue that relates to the clinic as a whole and to management through partnership. Consequently, the association of the doctors with the management of the health care establishment is seen as a joint venture to decide upon and design medical projects.

3. Discussion and implications

From the analysis carried out, it is possible to characterize the conflicts which set doctors apart causing the cognitive and socio-cognitive conflicts as outlined by Charreaux (2002) and Moscovici and Doise (1992) consecutively. Each present and interpret the situation differently. The difficulties of setting up the T2A funding scheme, the power struggle between doctors and administrators (with regard to the appointment and dismissal of health staff, for example) can be attributed to the medical sphere's lack of involvement in governance, an absence of power supervision and of decisional organization. Also, the clinic had to reinvent solutions *ad hoc*, as in the creation of a place for

dialogue, the focussing on a symbolic federative project. The latter did not aim to resolve conflicts of interest in the agency theory's sense of the term but rather cognitive conflicts (Charreaux, 2002).

In addition, a phenomenon known as psychological reactance can be observed among doctors, brought to light by Brehm (1966) and elaborated by Doise *et al.* (1991). In our case study, it seemed to manifest as a reaction on the part of the doctors to a feeling of a loss of independence. In the tradition of the work of Brehm (1966), psychological reactance is all the more pronounced among doctors with a necessarily specialized knowledge of their work. The establishment of these phenomena leads one to think that they could have things in common with one of the conditions leading to cognitive conflicts.

Consequently, in the field of this research, it is above all the permitted supervised confrontation through meetings between doctors and the management that enabled the construction of a new opportunity: the launching of a new medical project. Ultimately, it is the punctual confrontation of wills and interests, but most of all of behaviour between doctors and the management in monthly meetings which led, in part, to favour the image of the clinic and to its notoriety. The sense of this approach can be found in the cognitive theory which gives great freedom of action to those involved, to favour innovation in particular. Following the example of Charreaux's (2002) work, clinic A's case highlights the issues of cognitive conflicts with regard to collective collaboration. It is the existence and joint recognition of different cognitive schemes that makes the launching of a new medical project possible.

We can legitimately think that the establishment of this collaborative space was made possible by the decision of clinic A's management to create meetings, thereby minimising the new mechanisms of governance set up by the 2007 Hospital Plan. All the more so in that dialogue can take place in a formal or informal atmosphere in these meetings and they allow consultation to take place between the different domains.

Moreover, if we refer to the probing work of Charreaux (2005), it would be reasonable to think that the State is trying to 'unbias' the behaviour of doctors in order to limit the significant health expenses. In his analysis of what behavioural finance has to offer and of cognitive models for company governance, Charreaux (2005) highlights the recognition of behavioural conflicts as well as interest and cognitive conflicts. According to the author, behavioural biases are broader than cognitive conflicts, as they encompass emotional and unconscious biases. In addition the author distinguishes individual biases from collective ones within an organisation and underlines the multiplicity of biases and the difficulty in identifying and defining them precisely. In our case study, the behavioural biases of the doctors could be related to their over-confidence and at times to their pride. In other words, the behavioural biases of doctors are necessary in the practice of medicine: a perfect knowledge that creates an over-confidence. For this reason, the State has a negative view of doctors' behavioural biases and tries to manage, discipline, to free them from bias. The alternative proposition of the PSPH clinic is to integrate the behavioural biases, and let the cognitive conflicts emerge during the consultation meetings. The doctors and the management consult each other, share their knowledge and ultimately unite to "sell" a project to the establishment's governing body, the Management Committee. It follows that the project is accepted (even though for two years no proposition had been made to the Management Committee). The management and the Management Committee congratulate themselves on their accomplishment: the launching of a medical project to improve the clinic's care as well as its reputation.

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