The Equivocality between Control and Management by Physicians: An Overview from Hospital Boardroom

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Abstract: More attention was paid to date to the one-tier system than the two-tier one, in studying the relationship between hospital and physicians within the governance arena. We aim to highlight their contribution in either supervisory board or management board role performance via the board process and using social identity and integration perspectives. Based on the French hospitals’ case, we suggest a theoretical background for future empirical research.

Keywords: dual board, physicians, integration, board process

Introduction

The French public hospital board: A transition from a unitary form to a bicephalous one.

The relationship between hospital and physicians is evolving to the extent that today they play a major role even on the hospital board. Recently, French authorities introduced a new reform concerning the public hospital governance. Before the introduction of the recently introduced law known as “la loi patients, santé et territoires”, French University Hospital Centers (UHCs herinafter) are governed by the board of directors. According to the Public Healthcare Code, this deliberative instance will be substituted by the supervisory board (le conseil de surveillance) and the “Chief Executive Office” (le conseil exécutif) will be replaced by the management board (le directoire). They have substituted a one-tier governance system (the board of directors) by a two-tier system (the supervisory and management boards). Thus the government wants to restore one leader in public hospitals, especially in the UHCs, who would be the chairman of the management board. According to the government, this would create an equilibrium of power between managers and experts who are the physicians. Indeed, the recent law famous for “hôpital, patients, santé et territoires” (hereinafter HPST) seems to redefine roles of both managers and physicians in the boardroom. In addition, the curative body is present either in the management board (hereinafter MGB) “le directoire” or in the supervisory board “le conseil de surveillance” (hereinafter SUB). Concerning the first governing agency, its vice chairman is the president of the Establishment Medical Commission. And as far as the second governing organ is concerned, it’s composed of representatives of local authorities, medicinal staff and patients.

However, knowing that those two organs are mutually exclusive, these divide physicians into two categories: on one side, those who participate in elaborating and executing the hospital strategy and on another side, those who participate in monitoring and advising managers. How can this physician’s double role improve the MGB and SUB role performance?
The HSPT law defines mainly the composition and some roles of the members of the SUB and the MGB and don’t specify the nature of relationship between members, and especially they are attempted to improve the performance of the UHCs.

We propose another look at the legal version through the addition of the integration, process and role perspectives. Our theoretical manuscript is articulated as following: First, we will deal with the hospital-physicians relationship in the light of the corporate governance. Then, those physicians will be implicated in the board concern through an integration mechanism, which constitute the follow part. After their integration, we will focus on their involvement in the board process to improve the role performance of both the management and supervisory boards.

Theoretical Background

The corporatization of hospital governance: the fate of hospital-physicians relationship?

Eecklo et al. 2004 argue that “principles of corporate governance cannot be translated into the hospital sector without specific adjustments”. The compliance with those codes of governance relates obviously to the hospital board. Moreover, this transition is emerging from board metamorphosis: From a philanthropic model to the corporate one. In fact, Alexander et al. 1988, make a distinction between the philanthropic board model and corporate one within the hospital industry. In addition addition the adoption of the corporate board model, in comparison to the philanthropic one, has a positive effect on either organizational performance (Molinari et al. 1995) or changes requirements (Alexander et al. 2006).

Public hospital corporatization seems to be an issue when those organizations are under competitiveness and social pressures (Alexander et al. 2006). This board metamorphism also concerns the relationship between the hospital and physicians, giving that those later are considered as stakeholders and actors at the same time. Scott 1982 define this link as “an arrangement for structuring the work between a professional participant and professional organizations”. If we could name this relationship “Professional to Organization” (P to O) , Kaissi 2005, had used the same models to develop “Professional to Professional”(P to P) relationship, which links the hospital manager and the physician. Based on the concept of “game of powers”, the author concludes that the party who has more power in a given hospital task ends up his goal and the effectiveness of the organization depends on the degree of equilibrium of power between the two parties.

Those descriptions of hospital-physicians relationship seem to take an interest in its managerial side and underline the behavior of the two parties towards each other. However, our reference is physicians, and we aim to focus on both managerial and governing sides by highlighting their behavior towards the hospital board. This organ seems to receive more physicians within its corporate model (Weiner and Alexander 1993). Those studies are run within the context of one tier system. Here, in French hospital context and according to the Public Healthcare Code, the French UHCs are governed by the dual system: supervisory and management boards. Such a a new internal mechanism of governance, the two-tier system, separates clearly between management and control. In addition, physicians are present in the two boards.
The Social Identity Perspective:

Before integrating physicians in the boardroom, let’s keep an eye on how the other members appreciate them. We propose to consider doctors as an outgroup comparing to the managers or other actors, whom both are regarded as an ingroup. Hence, as elaborated by Tajfel and Turner (1987), the social identity theory stipulates that “more favorable perceptions of the ingroup relative to the outgroup derive from a motive for a positive social identity, a motive which can be satisfied by perceiving the ingroup more positively than the outgroup.” (in Mullen, 1991). This creates a positive distinctiveness between, on one side, the doctors who represent the experts and the others who serve the function of management. Giving that, the expertise reduces the uncertainty concerning the decision making, the ingroup (the managers and others) will perceive the outgroup (the physicians) positively. In addition, giving the social identity theory of leadership, as developed by Hogg (2001), the recognition and the positive perception of the outgroup by the ingroup, this legitimize the statute of the relations between the subgroups (the ingroup and the outgroup) and create a context favorable for the sharing of power. Furthermore, the positive social identity emanate from a decrease of “the ingroup bias”, which generate a goodwill to work together. And, in our case, the positive social image concerns either the management board and the supervisory board. However, this seems to be at a certain description of what links the physicians with others actors and possibility of a merger between them as members of one group, which should be accompanied by a factual operation that to say the integration.

The Integration Perspective

Rundall et al. 2004 established their theory of physician-hospital integration on institutional and economic market theories in order to highlight the balance of power between the physician and hospital. Before hospitals had appointed physicians to ensure the care, they were considered as workers like others. Little by little, they begin to possess a background within the hospital, they use their expertise as a tool to access to management position and then the upper echelon of the hospital hierarchy. The negotiation between the two parties is usually characterized by cost and experience deals. According to Schramko 2007, using a contractual perspective and in-depth interviews method, argued that the relationship at stake, may be more effective in case of some “characteristics are evident before, during, and after the contract is signed”. Robinson 1997 had said, before, that this relationship is a sort of coordination under pressure from market competition. This gives a strategic dimension to the nature of this link (Shortell 1997), which generates a major development in the healthcare market (Cuellar and Gertler 2006). In addition, Alexander et al. 1986 argue that this strategic connection seems to be under competition, regulation, and corporatization.

In fact, the involvement of physicians is divided between management (Leat, 1994 and/or governance. Goes and Zhan 1995, and Succi and Alexander 2004, study the effect of those involvements in governance and/or management on the hospital performance. Concerning the first, they realize that the hospital ownership by physicians and the integration of the hospital-physician financial relationships are more effective, in terms of hospital performance, then the involvement in governance matters. The second integrates medical staff size and diversity and percentage of salaried physicians as moderate variables between physicians executives/board members and hospital efficiency. Thus, within the board of directors, physicians occupy simultaneously a double role: either executives or decision makers. The belonging to the same governance organ seems to reinforce interest alignment between the
two functions. However, the two-tier system creates segregation between management and governance. This rhymes with Fama and Jensen’s (1983a) proposition, they argue that for non-for-profit board is concerned, it’s more convenient that control and management decisions are separated because this avoids agency problems. In fact, those decisions characterizes the roles of supervisory and management boards. Thus, respectively, the supervisory board ensures the roles of ratification and monitoring and the management board assures initiation and implementation ones.

**Physicians board process:**

In addition, in order, to apprehend better different physicians’ roles, we choose to focus on the board process. Forbes and Milliken 1999, Chin and David 2001, Ong and Wan 2007, Ees et al.2009 and Zona and Zattoni 2007, had used three antecedents of the board process , which are the cognitive conflict, the use of skills and efforts norms. They try to link those elements to the three different roles of the board. Thus, drawing our inspiration from those searches and those done in the hospital sector (Kane et al. 2009), we try to conceptualize the relationship between the physician’s role and the decision process in order to show to what extent their integration in governance can be successful. Our following strategy analysis, stipulates a combination of the board roles and board process before enunciating our hypothesis. All things being equal, we’ll neither emphasize some board characteristics such us composition, size, tenure...etc. nor considering the influence of those variables and other external constraints on distinct relationships described as following:

**Physicians board roles:**

Hung 1998, defines a typology of the role of board of directors using the contingency view as an extrinsic influence perspective and the institutional prospect as an intrinsic influence perspective. He found six roles, which are: control, strategic, linking, coordinating, maintenance and support. Cornforth 2001 broke those roles into 17 functions (for more details see Cornforth 2001). However, However, Lee et al.(2008) are based on “three main roles: mission and strategy setting, performance evaluation and oversight, and external relations (Carver 1990; Chait, Holland and Taylor 1991)” to define those of the hospital governing board. In addition Pointer and Orlikoff 2002 p.73, points out three roles of the hospital board, which are policy formulation, decision making and oversight. If we want, to sum up, them, we find that the last four ones from the service role. In fact, governance scholarship classifies, otherwise, those roles of the board by three categories: Strategy, control and service (Zahra and Pearce II 1989, Ees et al. 2008, Ong and Wan 2007and Chin and Wai 2001). Those Those roles are often associated to the board of directors and can be used to the SUB (Ees et al.2008). As far as the MGB is concerned, the main role is the strategy. And logically, the MGB is controlled by the SUB. In the matter of strategy, the SUB insures the ratification and the monitoring of the strategy initiated and implemented by the MGB.

So given that physicians belong to the two organs, they will be a constraint to gather clinical, managerial and governance responsibilities (Succi and Alexander 1999).

**The physicians in the MGB :their strategy role**

Shortell 1989 had underlined the importance of strategy formulation and implementation for the hospital board. In the two-tier system, those functions are insured by the MGB. This organ resembles physicians and managers. As far as physicians are concerned, they represent the
interests of specialists either permanents or not. In the French UHCs, this grouping of physicians is named “Medical Establishment Commission”.

According to the HSPT law, the MGB of those organizations, has the hospital director as the chief executive and the chairman of the Medical Establishment Commission (hereinafter MDC) as the vice-president. Those appointments are like a co-optation between the MGB and the MDC. The concept of co-optation is drawn from the definition of Selzenick: “the process of absorbing new elements into the leadership or policy determining a structure of an organization as a means of averting threats to its stability or existence.” (Scholten and van der Grinten 2005).

In fact, the MDC and the MGB seem to play the same role of, respectively, the Staff Executive and Board Executive, as described by Scholten and van der Grinten 2005 in their case study. The authors argue that the “juxtaposition” between the Staff Executive and the Board Executive can be structured either by joint regulation or collective bargaining. The “game of powers” can result in the fact that the “Executive Board is held hostage by medical staff” via the Staff Executive. This former defends the medical staff interest when it’s about decision making and lets the Executive Board assume his final responsibility..

However, despite that the governance reality could be characterized by either hidden or showed conflict situations, this does not neglect the notion of “board value creation” (Huse 2007, 2009). In fact, since that the MGB is considered as a discussion space which allows physicians to participate effectively in the decision making, this gives them the opportunity to embrace the hospital “health” with an economic and strategic eye, without burying the clinical and medical value. This may put them at a crossroad of decisions and under a growing economic and social pressure, they should combine simultaneously medical, social and economic values. Consequently, according to the French legislator, the MGB is responsible for many strategic tasks in several axies (financial, quality, human resources). For example, as far as the financial axis is concerned, physicians within the MGB contribute to the elaboration and the decision on the most strategic financial document which is the Provisional State of Revenues and Expenses. It describes mainly the financial health of the hospital and what actions are likely to be done in order to realize the financial hospital balance. In case, of realizing a surplus, they undertake a compensation policy.

Proposition A: The implication of physicians in the MGB infers that they will be motivated to consider the economic wealth of hospital through the implementation of hospital strategy.

The appointment of physicians at the MGB gives them an additional responsibility. They try to conciliate between medical and managerial matters. The effort norm is translated here as the time and attention consecrated by the physicians’ members to the boards’ tasks. Giving that they find themselves in a new position as decision makers, they try to find equilibrium at their agenda level, between, their medical intervention and board meetings. In addition, they will use their skills to propose a few alternatives face issues. Those options, consequently, will be discussed with managers within the MGB. In fact, this organ resembles more to “discussion” group than “a confronting” one. Physicians create a cognitive conflict towards their managerial counterpart. This conflict is qualified by “positive” (Zona and Zattoni 2007) forasmuch as it “…promotes an open debate and positive disagreement”. Meanwhile, physicians should have some managerial knowledge and the hospital should encourage and propose an adequate training for them.
Proposition A1: The use of skills, the effort norms and the cognitive conflict increase the implication of the physicians in strategy making within the MGB.

The physicians as members of the SUB

According to the HSPT Law, the SUB is composed of three electoral colleges resembled in two groups: The first group is constituted by the outsiders: (1) The representatives of the territorial authorities (2) and skilled persons and the second group represents the insiders: (3) the representatives of medical and non medical staff. And the SUB chairman is elected among the outsiders.

The physicians in the SUB: Their strategy role

The SUB takes in interest also the strategy matter. Ees et al. 2008, highlight the strategy role of the supervisory board. The law stipulates that this decision group is responsible for the involution of the Establishment Project. Which document prepared by the MGB, dress the hospital strategy over a maximum duration of five years.

By this way, the SUB plays the ratification role. In addition, physicians’ members who serve on the board should have some managerial skills, in order to participate effectively before, at this point of, and after the decision making.

In fact, physicians’ decision makers on SUB -as their peers on the MGB- ,proves a successful physician integration and may play an “opposing force” role towards their peers on the MGB. This may create positive" conflict of interests between the two groups, which motivates more SUB physicians’ members. A priori, they will not play the role of “rubber stamp” (Mace 1972, Jonsson 2005).

Proposition B: The implication of physicians in SUB reinforces their contribution in the strategy making.

The capability of physicians SUB members to participate, actively, on the deliberation of the Project Establishment and other strategy tasks is based on their interaction with other members. This potentiality measures the extent to which physicians' members use their expertise to serve the SUB. Consequently, the debate within this organ, gives a trustee to the board. Giving that the SUB is served by. Moreover, the medical or not medical staff representatives, the local authorities’ representatives and other skilled persons, this diversity creates a cognitive conflict between those groups. According to Forbes and Milliken 1999, this multifariousness of knowledge engenders “the consideration of more alternatives and the more careful evaluation –process that contributes to the quality of strategic decision making in uncertain environments”.

The physicians in the SUB: Their service role

By the service, we target mainly the advising mission done by physicians for the MGB. Zona and Zattoni 2007, Ong and Wan 2007 and Ees et al.2008 ,argue that the board ensures the advising service for the managers. Stiles and Taylor 2001, substitute the service role by institutional role which describe the intervention of the board as a link between the firm, the stakeholders or the shareholders. Zona and Zattoni 2007, are based on the institutional point of view and replace the service role by the networking service. However, this later seems to be insignificant in the case of the French UHCs, given that the networking as described by
governance scholarship, join the resource dependence role (Hillman 2000), and both argue that the board supply the resources for the organization, however, those organizations’ activity is financed by the government. Meanwhile, we aren’t interested on this role, which links the hospital board and its environment as much as we are interested in the relationship between the two bodies (the SUB and the MGB) within the boardroom, so we focus on the service insured by the SUB towards the MGB.

Given that, physicians, as the members of SUB, are endowed with competencies related to the hospital internal process, they will be able to help managers concerning this point and provide very useful information for them.

Proposition C: The entailment of physicians in the SUB enhance their attendance in its service role.

As counsellors, physicians sitting in the SUB are expected to do not hesitate to propose their recommendations, during the session, about the strategy suitable by the MGB. Thus, their advice should be based on their time and interest accorded to advisory mission. Those effort norms emanate, also, from the board, in the sense, that it insures training and upgrades each group in order to have the “right mix of skills” (Cornforth 2001). And as far as the upgrades are concerned, they resemble the actions of maintenance of the board, precisely, Johnson 2009 p 364-65 deals with board member education, by sponsoring « initial and ongoing programs for board members, which can include orientations, annual retreats, and regular items on the board’s meeting agenda; ”Being trained, physicians will be able to use their experiences and competencies as a value added, for example, to avoid some management risks.

Proposition C1: The use of skills, the cognitive conflict and the effort norms increase the implication of physicians in the SUB service role.

The physicians in the SUB: Their monitoring role

The monitoring role is concretized by the setting up control systems of the management in order to supervise the behaviour of the MGB. The lawful perspective stipulates that the SUB proceeds at anytime to the verification and control tasks, with freely access to the documents which are estimated required to accomplish their mission. Members of this organ appoint also a statutory auditor if necessary and the hospital account is submissive to a certification. The conceptual origin is the agency theory (Fama and Jensen 1983). In fact, the SUB should be appraised about the operational and strategic activities of the MGB, since the members of the first organ seem to be “sworn” by stakeholders to protect their interests against the opportunistic behaviour of managers.

Proposition D: The involvement of physicians in the SUB, improves its monitoring role.

The physicians will be able to exert a monitoring role, if they have the required information, and they are supposed to analyze and interpret it, in order to detect and assess the gap between the expectations of the different stakeholders’, they contribute to propose some improvement acts. That propositions emanate from different components forming the SUB—physicians’ included. Since, Beekun and Ginn (1993) underline the diversity of board hospital, and according to them, it’s composed from (1) “defenders” who stress internal information scanning” , (2) “prospectors” who “usually sacrifices internal efficiency for external
effectiveness and emphasizes external information scanning”, (3) “analyzers” who “seeks a balance between its internal and external information needs” and (4) “Reactors strategy” who seems to resemble to three precedent categories, hence, this mixture of groups enhances the numbers of alternatives before decision making. If it be so, the physicians’ participation creates a cognitive conflict, which is generated by their skills and experience concerning suitable methods when a deviation by the MGB occurs. Their fiduciary responsibilities become higher, when they participate in monitoring role, so they amplify their efforts in order to be up to different stakeholders’ expectations.

Proposition D1: The use of skills, the effort norms and the cognitive conflict, boost the involvement of physicians in the SUB monitoring role.

The separation between the physicians' decision makers:

The creation of partition between management and supervisory boards is likely to create within the physicians two categories of administrators: The first category mainly takes care of the formulation and the implementation of the strategy. And the second one is dealing with it’s monitoring and ratification. After integration of those actors in governance, the two-tier system seems to generate a kind of apportionment of roles, which have a double-sided implication: The collaboration or the dispersion. Since Baron and Kerr 2003 (p169-171) deal with “a manipulating social categorization” which ramify into decategorization and recategorization. Within the two-tier system, a social group, seems to be a subject of decategorization when it is divided into two groups: “Strategists” and “Inspectors” In consequence, the recategorization may induce a unification of the two categories.

Based on process studies, the service role insured by the SUB gives the impression that advising task generate a coaction between the two groups. In fact, fact, physician vigilance towards this integration in governance, cannot cancel a coalition, giving that they will be able to make a decision that may influence interest of each. Really, physicians seem to be more impregnated in the internal hospital process than in governance and management one.

Thus, use of skills, cognitive conflict and even the effort norms will be arrayed for the sense that physicians-whether they belong to the MGB or the SUB- want to be and not that whole of the two-tier system supposed to do. This can bias the board process.

Proposition E: The separation between the two groups cannot hide a collaboration spirit, which hinders the board process.

Meanwhile, the adherence of physicians to different and separate compartments of the boardroom( the MGB or the SUB) force them to comply with principles of governance’s best practices (see Carver and Carver 2009).

Proposition F: The separation between the two groups generates an independence which accelerate the board process.

Conclusion:

Our propositions are based on board process to analyze the integration and contribution of physicians in the board role of French University Hospital Centres, which are characterized by the two-tier system. If physicians are integrated in management and governance, they
should play the role of the board value creator (Huse 2007). Their coalition seems to be an externality, if they decide to manipulate the decision making.

In our paper, we are emphasized on the role expected of physicians both in the management and the supervisory board more than the transition from the one-tier system of the French UHCs to the two-tier one, given that we are interested in the possibility of collaboration between two groups, which represent management and expertise. In fact, we are integrated in the processes of board vision (Huse 2009) which try to open “the black box” and describe how board members interactions (Macus 2008) can contribute in the board role performance.

Not emphasizing on neither some characteristics of the board such as composition, structure, tenure nor the influence of external environment this may move the reality far away. However, our aim is to contribute, precisely, to define the physicians' governance role expectations.

Moreover, the two-tier system, divides physicians into two categories of decision makers. The first category is represented by the SUB which participates in strategy making, controls and advices the MGB. This former represents the second category which has mainly the strategy making as a mission.

Given that the access to the boardroom seems to be a barrier against researchers (Stiles and Taylor 2001 p. 21) to analyze closely the board process, we will work on a questionnaire to be sent to the physician board members population.

References:


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