

“A cognitive reading of hospital governance or how cognitive conflicts can generate cooperation”

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SECTION 3. General issues in management

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A cognitive reading of hospital governance or how cognitive conflicts can generate cooperation

Abstract

This research comes within the specific context of governance reform in health institutions. The aim of this article is to show the interest and impact of the cognitive approach to governance (Charreaux, 2002) applied to the health sector. The aim is to answer two main questions: how do cognitive conflicts come about between the administrative sphere and doctors? In what way can these cognitive conflicts be vehicles of cooperation between the former and the latter? The results of our study show how cognitive conflicts in the sense of Charreaux (2002) or socio-cognitive conflicts in the sense of Moscovici and Doise (1992) can, once they have been identified, enable the creation of cooperation and a realization of common interests through, notably, the launching of a medical project.

Keywords: governance, organization, conflicts of interests and cognitive conflicts, behavioral bias.

JEL Classification: I18.

Introduction

This research comes within the specific context of governance reform in health institutions in France. Over roughly the last twenty years, the relation between the healthcare and management roles has evolved. Doctors must make strategic choices; maintain the budgetary balance, while reconciling the daily decisions that go with providing healthcare for patients. Our work focuses on the relations and conflicts between administrators and doctors in the particular context of the new rules of hospital governance proposed by the State in France. We will therefore refer to works that propose a cognitive approach to governance and cognitive and axiological conflicts in order to support our enquiry (Charreaux, 2002, 2003, 2005).

Our study has the objective of finding out if the observed conflicts between the medical and management spheres in our case study can be qualified as cognitive conflicts. The aim is to show the interest and impact of the cognitive approach to governance applied to the hospital sector. This article therefore has several intentions: (1) to identify the cognitive conflicts between the healthcare and administrative staff; (2) understand how they come about; and lastly (3) research the actions that will enable the management of these conflicts with a view to establishing a lasting cooperation between the medical and administrative spheres.

In the first part, the main theoretical frameworks used are outlined. The second part concentrates on the presentation of the qualitative research method based on the study of one unique case. The case is

analyzed in the third part in terms of the cognitive approach to governance and cognitive conflicts. A fourth part deals with the discussion of the results.

1. Literature review

1.1. Hospital governance. Quoting the report by Denis (2002) entitled “Governance and management of changes in the healthcare system in Canada”¹. Budet defines hospital governance as “*systems and practices that allow actors to develop a plausible representation of their future, to conceive and establish effective strategies for change and to employ productive values of confidence and solidarity. [...] Governance relates to the organizational design of the healthcare system and to the distribution of responsibilities and capacities of influence among the different entities of which the system is composed. It has also to do with the systems and mechanisms of production, diffusion of information and the modalities by which the organizations and professionals are financed*” (translation of quote from Budet (2003, p. 708)).

This definition of hospital governance seems to be far removed from the said “corporate” governance. As numerous authors explain (in particular Charreaux, 2002, 2005; Martinet, 2008), there are several approaches to corporate governance, but authors agree that the approach that has made the most significant developments favors the disciplinary dimension of the shareholders’ role and focus on the study of the distribution of the created wealth. From this view, the central logic of corporate governance rests on a financial model which aims to monitor the

¹ Denis J.L. (2002). “Governance and management of change in the healthcare system in Canada”, *Commission on the future of healthcare in Canada*, Study N 36, Montreal.

directors, establishing thereby the “rules of the managerial game” to avoid risks of damaging performance and spoliation of shareholders, thus enabling the latter to be assured of the profitability of their investment (Charreaux, 2002, p. 630). Transposed to the hospital context, governance necessarily takes on a whole other meaning as *“hospitals do not fall under a financial logic based on one unique actor (...). They bring together an ensemble of internal and external actors (the stakeholders) (...) to tackle problems, the primary aim of which is to provide care for patients”* (translation of quote from Cauvin and Le Joly, 2003, p. 711). According to Cauvin and Le Joly (2003), hospital governance is project-oriented and strategic: *“it must be substantial (its material being the same activity of the hospital) where corporate governance is formal and procedural”* (ibidem, p. 712). Hospital governance has to associate pertinent actors who must contribute to the success of the “project”, be they internal or external, with respect to the hospital (Limpens, 2003; De-champ and Romeyer, 2006).

1.1.1. The clash of two logics: medical and managerial. One of the particular issues proper to the health sector seems to be a fundamental divergence: the divergence of views and interests between *“those whose job it is to provide care, and those whose job it is to manage the resources which the former need to work”* (translation of quote from Dumond, 2003, p. 71). Thus, two roles must co-exist in a health institution without having, *a priori*, common practices and values: on the one hand, the healthcare staff have the role of welcoming, understanding pain or suffering, appeasing and providing treatment, etc.; and on the other hand, the management’s role of managing, financing and balancing the accounts, etc. Their values are clearly different. The doctor’s role gives rise to a feeling of reservation with regard to profitability. In contrast, for the administrator, calculating profitability is continuous in terms of the resources used. Nevertheless, managing and treating are complementary in that one makes resources available that are necessary for the other. This complementarity was minimal up to relatively recently: healthcare staff had the use of resources without necessarily having to refer to the management. For Dumond (2003) these two worlds kept each other in mutual ignorance, even contempt; and outside of professional conscience and the will of each individual, there was no incentive for them to cooperate. Romatet explains that *“doctors or healthcare staff [...] had made an activity of their hospital life that was free of management worries and direct economic consequences or those brought about by their actions”* (translation of quote from 2008, p. 1). Healthcare staff would give an account of

their activities to their peers or even to patients, but rarely to the management.

1.2. Cognitive theories of governance. Cognitive theories of governance have been developed and improved by many authors (Lazonick and O’Sullivan, 1998; Williamson, 1999; Aoki, 2000; O’Sullivan, 2000; Charreaux, 2002, 2003, 2005). They are interested in the process of value creation; more specifically in the fundamental mechanisms of value creation and in particular how directors recognize, seize and transform opportunities for growth in organizations. In this perspective, the role of governance is not only to define the scope of the directors’ discretion, but also to aid in the development of the company. This is achieved by the exchange, prescription and capitalization of knowledge and/or competences mobilized or to be mobilized internally or externally. Summarized by Charreaux (2002, 2005), this approach gives rise to new theoretical foundations that can be mobilized to build a veritable cognitive theory of governance. In the cognitive perspective, governing companies is defined as *“the ensemble of mechanisms that make it possible to have the best potential for the creation of value by learning and innovation”* (translation of quote from Charreaux, 2003, p. 638). The cognitive approach falls under a procedural logic that leads to the creation of value, born out of cooperation between shareholders and directors. This cooperation allows the confrontation and creation of knowledge as well as the development of mental schemata. According to Hodgson (1998), companies are *“mainly a repertoire of knowledge”* (translation of quote from Charreaux, 2002, p. 8). Consequently the creation of value would depend on the company’s capacity to create knowledge and thus, to be enduringly profitable.

Cognitive theories of governance put a particular importance on the notion of cognitive conflicts. Cognitive conflicts should be differentiated from conflicts of interest as viewed by the shareholder theories of governance. Where conflicts of interest are linked to the distribution of income, cognitive conflicts come more fundamentally from a difference in cognitive or axiological (to do with values) orientation, in other words a different representation of the world as specified by Charreaux (2002). These conflicts take place particularly in the social interactions within a decision-making group. Charreaux (2002) indicates that cognitive conflicts *“occur during the construction and evaluation of the strategic relevance of investment opportunities. Directors, administrators or important shareholders can make incompatible propositions or disagree with regard to the industrial viability of a project based on the same information, because*

they have different cognitive models” (translation from ibidem, p. 30). According to the author, axiological conflicts go well beyond questions of interest or cognitive models in that they can influence the decisions of directors worried about preserving principles of equity or ecological risks for example. The cognitive approach is interested in the issues of cognitive conflicts with regard to collective collaboration and the creation of value. Charreaux (2002) explains that where it is preferable to reduce conflicts of interest as a loss of efficiency, this is not the case in terms to cognitive conflicts. According to the author, innovation, not to say simple adaptation, is favored by the joint existence of different cognitive schemata.

Apart from these cognitive and axiological conflicts that are part of an approach to the governing of an institution, other authors were interested in the notion of socio-cognitive conflicts more anchored in a sociological approach (Moscovici and Doise, 1992). These conflicts arise when different incompatible ideas or options are proposed within a group where a decision needs to be made. This conflict is termed social in that each subject must defend his or her position in front of the other members of the group. The decision process within the group will be all the more complex, if there is a high level of diversity of opinion among the actors and if what is at stake because of the decision is high. Also, the more relationships are informal and governed by a small number of rules, the more actors, even those in the minority, are inclined to interact (Moscovici and Doise, 1992). In this perspective, and following the example of works by Charreaux (2002), the existence of diverging propositions can favor the creation of innovative solutions. Thus, socio-cognitive conflicts seem *a priori* beneficial for the creation and exchange of cognitive resources. Nevertheless, in a study carried out on investment capital and the issues of syndication for directors, Stevenot-Guéry explains that in practice, socio-cognitive conflicts appear to be “*difficult to regulate and, due to an inefficient system of governance, end in situations of deadlock and tensions which threaten the very foundations of cooperation*” (translation of quote from Stevenot-Guéry (2007, p. 158)).

The aim of our study is to test the relevance of the cognitive approach of governance in the framework of hospital governance. We want to find out, first of all, if the conflicts observed between the medical and management spheres within our case study can be qualified as cognitive conflicts in Charreaux’s sense of the term (2002). This work must enable us to un-

derstand, on the one hand, how they come about, and on the other, in what way the latter can favor collaboration and be a source of innovative developments.

2. Methodology

The procedure used rests on the study of a unique case: a private non-profit organization accepted to Participate in the Public Hospital Service (PSPH). The case in question is referred to henceforth as South Clinic. A PSPH clinic has the particularity of being a private non-profit institution. The study was carried out between December 2006 and April 2008. In the framework of this research, three main sources of data were mobilized.

1. A semi-structured interview constitutes the major source of data. Fifty-five interviews, on average an hour and a half long, were carried out following an interview guide. The latter was set out at the end of our literature revue and refined following our first interviews with the Managing Director of the clinic. The interviews were conducted with all the governing bodies of the clinic and different people in charge of daily activities, as well as the Head Physician, doctors, healthcare assistants and nurses.
2. The second source of data lies in documentation. We were able to consult fourteen internal and sixteen external documents. This documentation, particularly rich, allowed us to complete information obtained by interview, in particular with regard to understanding new regulative measures.
3. The non-participative observation completed the collection of data. We have had in particular the opportunity to acquire an office within the clinic and to conduct our observations over a period of thirty-four days, which enabled us to attend three Management meetings, termed ‘executive meetings’, on the management and daily organization of the clinic.

3. Analysis of the south clinic case

The clinic was specialized in geriatrics and gerontology and fulfilled a mission for the public hospital service while keeping its private non-profit status. The PSPH status is crucial for the clinic, as it can receive a guarantee of resources from the State.

The authoritative bodies with the real power within the clinic are the Management Committee firstly and then the managing director. A Management Committee therefore runs this non-profit organization. It appoints a President, Vice-President, a Secretary and a Treasurer for a period of two years. The Management Committee is invested with the most extensive powers to manage and run the company.

The Management of the clinic is at the center of operations and operates an upward feedback of information via the Management Committee. The President of the Management Committee meets with the managing director of the clinic in a more or less informal manner.

The role of the director is to direct the company. He is legally co-responsible, in the same way the President of the Management Committee has a part of the responsibility in this respect. The director is responsible before the Management Committee for the proper running of the institution and for its financial, social health.

3.1. Identifying conflicts. The clinic was faced with an obligation – the conversion to a new service-based fee logic called T2A; and an option – the modification of its governance; the peculiar status of the “PSPH” clinic meant it was not obliged to change its mechanisms of governance.

3.1.1. The choice of not changing the mechanisms of governance. The law on hospital governance allows PSPH clinics to create an executive council and to set themselves up as activity poles. The clinic decided to discard both of these options. The explanations with regard to the executive council have two main arguments: the overly restrictive character of certain mechanisms of governance proposed by the law and the inutility of systems of interaction in view of the technical systems already present in the clinic.

Likewise, the decision not to use the activity poles prescribed by the law of May 2, 2005 was a choice that was deliberated upon by the clinic. Several reasons are given by the managing director for this choice:

“The reform by pole implies that doctors must, in addition to exercising their ‘art’, manage their teams. To me this seems impossible. From my point of view, one cannot practice two professions at the same time. Because of this point I am not in favor of the new governance. [...]. Everyone should be able to exercise perfectly their profession” (MD).

“I refuse to manage the clinic by pole. There is absolutely no point in our clinic, which is much smaller than a University Hospital. What’s more, in order for the poles to be genuinely autonomous, you would have to recruit or set up for administrative posts for each pole. One of the main consequences is the creation of a large cost. Also, and most of all, doctors in charge of poles would be given much more ‘managerial tasks’, and inevitably, this is less time devoted to medicine” (MD).

3.1.2. Establishment of the new service-based fee. With regard to the setting up of the ‘T2A’ service-based fee: for the management, the reform is posi-

tive in that it obliges doctors to become aware of their financial concerns.

Where the management voluntarily welcomes the T2A, this is not at all the case for the doctors. The latter recognize that in principle it is necessary but that putting it into practice is much more complex. First of all, it asks them to do an administrative job with a precise formalization of their acts. So doctors have the impression of having to develop ‘the mind of an accountant’ which seems to them an ‘impossible reconciliation’ between treatment and economics. In fact, the results of hospital exercises henceforth depend on what they are worth in terms of monetary value. According to doctors, it is therefore no longer the patients who are taken into account, but rather the relation of their illnesses to the budget.

Conflicts between the management and doctors have become major, considering the reversal of the situation between the management and treatment roles. Gradually, the management complains to doctors that no procedures are being respected: the recording of activities is illegible, coding for illnesses is often omitted, etc. The administrative staff’s procedures with respect to doctors multiply in order to retrieve missing medical information.

3.1.3. Increase in the number of meetings. In addition, the number of meetings grows and these are increasingly about good management and the organization of activities, particularly with regard to the allocation of resources and the control of decision-making processes for a management system that is much more strict and collegial, for which doctors are more and more unavailable.

These meetings end up being periodic reminders of the good use of available resources (staff, material, time management), putting doctors in a contractual system that depends on the defined health objectives.

This procedure seems to profoundly offend a large majority of doctors who see these decisions as an ignorance of the specificity of their activity, which demands, on the one hand, an autonomy of judgment and decision and, on the other, a very particular time management which fluctuates between reflection and action / detachment and urgency.

3.1.4. A feeling of loss of independence for doctors. Paradoxically, doctors also condemn the fact that they are consulted less and less with regard to decisions which they consider to be fundamental, in particular when it comes to recruitment or the dismissal of healthcare staff. Previously, they had the right to oversee and would meet with candidates. Since only recently they are no longer consulted by the management, who carry out some recruitment of staff.

In January 2007, a doctor categorically refused management recommendations that suggested he reduced his department's workforce. Eventually, the human resources department of the clinic imposed the 'name' of a nurse on the doctor in charge of the department. Doctors feel the need to protect their reserved domains of decision making and action. Thus, management intervention in recruitment and redundancy of healthcare staff becomes a particularly sensitive subject for them. Doctors' reactions are all the more acute in that they consider themselves competent and have a necessarily highly specialized knowledge of their job.

In June 2007, the director and the Management Committee met and noticed the discrepancy between the action being taken and the objectives that had been set: administrative slowness, a two year absence of suggestions for new medical projects, nonetheless necessary for the clinic's reputation; and the increase of conflicts between the administrative and medical spheres. The conflicts are over the perceived depreciation of the role of doctors, the loss of flexibility in the daily management of activities, as well as the reduced influence of doctors on recruitment procedures.

3.2. Seeking cooperation. *3.2.1. Towards the creation of consultation meetings.* Faced with this inertia and environmental pressures, in July 2007 the director and the Management Committee invited the doctors to meet in the clinic to talk with a view to kick-starting the institution's activity. These three parties decided together to suggest new solutions, which consisted in creating collaborative meetings between doctors and the management. Since July 2007, the management of the clinic has organized meetings once a month between the clinic's doctors and the management, with the aim of maintaining an exchange and a close and continued collaboration between the two parties. This initiative is particularly appreciated by the doctors, as the meetings are not very frequent.

The organization of these meetings is the result of a decision taken by the clinic; they have not been made officially compulsory. The management voluntarily initiated these meetings so as to increase encounters with healthcare staff but also with a view to regularly taking stock of new regulations, strategic action plans to be carried out, etc. These meetings, called "executive meetings" (administrative and medical executives) fulfil a desire to have a clear and shared policy that takes into account and promotes the interests of the doctors, the management and the patients. The meetings start with points on administration. During each meeting, a discussion about a new regulation to be put into

effect takes place. For each new measure, the discussion is open to all members to suggest and draw up a plan of action. Finally, the doctors share their potential requests/expectations of themselves as a group. If the request is considered important, the managing director of the clinic creates a project team in charge of evaluating the medical, financial and human needs of the request expressed by a doctor. A schedule is agreed upon by the group so that the progress can be presented quickly during the following meeting. If the managing director is convinced by the project and its evaluation, he submits it to the Management Committee, which may or may not give its approval. Generally, for each point that is discussed in the meetings, the executives concerned suggest a plan of action that is discussed with all participants.

3.2.2. Proposal and launching of a new medical project. This supervised and balanced collaboration allows for calibration, compromise and the exchange of information. In March 2008, during one of these meetings, the head of the medical department announced a request made by one of the clinic's doctors: to take charge of a new technique for the treatment of complex wounds in geriatrics. This medical project was submitted to the management on the doctors' initiative.

In the discussions and exchanges of knowledge, management and doctors' concerns ultimately converged. Gradually, both the doctors and the managing director realized they had the same concern: that of having the project accepted by the highest governing body of the clinic, the management committee. Proceeding in this way, they create a common interest; their concerns are mutually understood and accepted. Thus, the creation of an opportunity for dialogue, exchanges and the construction of a plan as well as the concrete implementation of a unifying project, made collaboration between the medical and administrative spheres possible. This renewed dialogue allowed for a better understanding/explanation of the issues linked to the T2A and made a change possible in the terms of the debate from a merely financial logic to one of organization and management "partnership" project for the clinic. In this way, the linking of doctors to the management of the health establishment is perceived as a joint venture in the conception and decisions of medical projects.

4. Discussion

The table shown below explains the approach of our analysis which aims to understand and qualify the conflicts observed between doctors and administrators, in support of the theoretical ap-

proaches presented in the first part of the article (Charreaux, 2002; Moscovici and Doise, 1992). We show the presence of mutual misunderstand-

ings between the doctors and administrators, which stem not only from conflicts of interest but also from cognitive conflicts.

Table 1. Analysis procedure of conflicts observed within the south clinic

Events observed	Views of the administrative sphere	Views of the medical sphere	Connection with theory
1. Establishment of T2A	<ul style="list-style-type: none"> ◆ Positive perceptions ◆ Culture of control and of result ◆ T2A forces the doctors to be more concerned with the financial preoccupations of administration: <i>"With the reform, there is an essential increase of information between management and the doctors. With this T2A part, doctors are in fact compelled to think in terms of job productivity"</i> (Assistant Director) 	<ul style="list-style-type: none"> ◆ Feeling of drifting from their central task associated with care (it is no longer the patient who is taken into account but the relation of their illness to the budget): <i>"With the reform, our patients come to be considered as "clients", subjects of profit and/or financial balance"</i> (Doctor 4). ◆ Service-based fee undermines their professional knowledge: <i>"With T2A, the doctors must describe their actions with precision. Yet this highly formalized procedure poses two major problems: their work is not quantifiable and medicine is not an exact science!"</i> (Chief Doctor DIM) <i>"The procedures that T2A wants to impose on us put us in a difficult position. We are obliged to devote 40% of our time to administration!"</i> (Doctor 1). 	Opposition between doctors and managers regarding the assessment of T2A, on the basis of the same information (Charreaux, 2002) The implementation of T2A is considered by doctors as incompatible with their professional knowledge, while T2A responds perfectly to the expectations of managers (Moscovici and Doise, 1992)
2. Mode of operation	<ul style="list-style-type: none"> ◆ The will to manage resources in the best possible way ◆ Research of a stricter management system, of a periodic evaluation: <i>"Once a week, I take stock of the situation with the doctors regarding the practice of their profession and the possible difficulties encountered: the service-based fee, if there is a problem concerning the affected resources. Also, it is an opportunity to present them with new measures taken by the management [...]"</i> (Doctor 3). 	<ul style="list-style-type: none"> ◆ Priority given to professional expertise ◆ Feeling of that their autonomy and personal organization of their work schedule has being questioned: <i>"We feel that a power struggle is developing, the sense and the nature of demands has switched sides and professional expertise no longer counts as priority number 1"</i> (Doctor 3). <i>"I have had enough of meetings twice a week! What I want is to practise my medical profession in peace"</i> (Doctor 8). 	The "knowledge" of each of the parties is reconsidered (for the doctors, the need to let them practise their profession autonomously/for the managers, the need to control) Charreaux (2002) defines knowledge as an open ensemble resulting from an interpretation of individuals on the basis of different cognitive models Each party presents itself and interprets the situation differently (Moscovici and Doise, 1992)
3. Recruitment process	Recruitment rests on budgetary constraints: <i>"The current situation imposes a budgetary austerity on the recruitment procedures"</i> (Director of staff management)	A depreciation of recruitment criteria based on the knowledge and skills of the doctors: <i>"I do not want to delegate to just any person the right to practise my profession in my job! When I say that I need a nurse I would like them to trust my judgment! It's nonnegotiable! The same goes for the quality of care!"</i> (Doctor 9). <i>"More and more, we are dependent on others, on the organization, and we no longer have a say in decisions. Before, recruitment was carried out by the professionals, not by the administrators. Things have changed and often for the worse because the criteria that is emphasized is no longer competence and understanding of the profession but rather financial considerations"</i> (Doctor 5).	The interpretation of "knowledge" regarding the need to recruit/dismiss between doctors and managers, differs (for the doctors, the decision to recruit/dismiss rests on their professional expertise and for the managers, it rests on budgetary constraints) The assessment of recruitment/redundancy criteria does not rest on the same basis of "knowledge" The proposals made by the management are deemed "incompatible" by the doctors who consider that they alone are able to identify the requirements for nursing staff.

From the works of Charreaux (2002) or socio-cognitive works in the sense of Moscovici and Doise (1992), it is possible to show that the parties concerned present themselves and interpret the situation differently. Indeed, the difficulties of implementing T2A, the power struggles between doctors and administrators (for example, regarding recruitment/redundancy of healthcare staff) can be explained by an absence of involvement of the medical sphere in governance, the control of power and the organization of decisions. Thus, the clinic must recreate solutions *ad hoc* (creating discussion meetings, focusing on a symbolic, unifying project). The latter did not, therefore, aim to re-

solve the conflicts of interest in the sense of the theory of the establishment but rather the cognitive conflicts (Charreaux, 2002).

Furthermore, we observe amongst the doctors a phenomenon revealed by Brehm (1966) and further developed by Doise et al. (1991), described as psychological reactance. Psychological reactance is defined as a negative reaction towards any attempt aiming to limit the free choice of a person. In our case study, it seems to manifest in a movement of reaction linked to the negative feeling of loss of independence on the part of the doctors. This state of reactance is observed in the comments of several

doctors: “the Management can tell me and impose on me what they want, I am a doctor and I practise my profession as I see fit” (Doctor 3), “It is certainly not them [the director and the Management Committee] who will teach me my profession!” (Doctor 6). This will to affirm their power is also manifested in their behavior (the case of a doctor who opposed the redundancy of one of the nurses for financial reasons). In line with the works of Brehm (1966), psychological reactance is all the more prominent since the doctors enjoy a necessarily specialized knowledge of their profession. These phenomena seen in our case study would lead us to believe that they could be one of the conditions for the emergence of cognitive conflicts.

In our case study, it is the controlled and authoritative confrontation during meetings between doctors and the management, which allowed the exploration and construction of a new opportunity: the launch of a new medical project. Ultimately, it is a specific confrontation of will and of interests, but above all, of the behavior between doctors and management during monthly meetings, which has, in part, favored the image of the clinic and its reputation. This approach is understood in view of the cognitive theory, according to which it is necessary to allow a greater freedom of action to participants, notably in order to favor the creation of innovation. Following the example of the works of Charreaux (2002), the case of south clinic reveals the issues of cognitive conflicts in terms of collective collaboration. It is the existence and the related recognition of different cognitive schemes which allow the launch of a new medical project.

We can legitimately think that it was possible to establish this collaborative ‘space’, notably because the management of south clinic minimized the formal governing mechanisms established by the 2007 Hospital Plan, while at the same time encouraging the organization of meetings, in which exchanges can be both formal and informal and in which consultation between different areas is authorized. Above all, this consultation is not limited to only financial concerns.

If we refer back to the works of Charreaux (2005), we could reasonably believe that the State looks to ‘de-bias’ the behavior of doctors with the aim of limiting significant healthcare expenditure. By analyzing the contributions of cognitive models to the governance of enterprise, Charreaux (2005) thus underlines the recognition of behavioral conflicts alongside conflicts of interest and cognitive conflicts. According to the author, behavioral bias is broader than cognitive conflicts, the former also including emotional and subconscious bias.

Moreover, the author distinguishes individual bias from collective bias within an organization and underlines the multiplicity of biases and the difficulty of denoting them and specifying their content. In our case study, the behavioral bias of doctors could be seen in their over-confidence and, on occasion, their pride. In other words, the behavioral bias of doctors is necessary for the practice of medicine: a perfect knowledge which creates an over-confidence. Thus, the State has a negative conception of the behavioral bias of doctors (leading to excessive health-care expenditure) and looks to define their parameters, discipline them, and make them unbiased. The alternative proposal of the PSPH clinic is to integrate behavioral bias, and let the cognitive conflicts emerge during consultation meetings.

Conclusion

The cognitive theories propose an interesting opening for the analysis of the governance of hospital institutions, where the coexistence of economic and medical objectives can create obstacles between the administrative and the medical spheres. While in the context of contractual theories, the principal objective of the governing mechanisms is to minimize conflicts of interest, in the context of cognitive theories, the cognitive conflicts can be sources of new development opportunities for the organizations.

The solution for south clinic was to integrate behavioral bias, and let the cognitive conflicts emerge. Indeed, doctors and management consulted each other, exchanging their knowledge, and ultimately allied with each other to “sell” a project to the authoritative body of the establishment: the Management Committee. It follows that the project was accepted (as no proposition had been made to the Management Committee for two years). The director and Management Committee are very pleased with the launch of a medical project that favors treatments as well as the reputation of the clinic.

The analysis of the case shows that efficiency of hospital governance relies on the management and on its Committee to involve the medical body in the management and decision making process of hospital institutions, but above all, on managing the coexistence of different but not necessarily diverging interests. This awareness on the part of the management of the behavioral bias of doctors, a source of cognitive conflicts, allows them to more effectively conceive of the financial consequences of their actions, making it possible for the two parties to understand one another through a project of creative and genuine transformation.

In conclusion, we consider that it is also the PSPH status that makes this flexibility possible. Indeed, as

we have seen, the PSPH clinic has a Management Committee with real power. Unlike the public hospital, this status gives sufficient latitude to its administration council. Thus, following the example of the works of Trazzini (2003), a relatively free Administrative Council can prove to be more responsible and thus more open to dialogue and to confront-

ing points of view, than a dependent administrative council with limited flexibility. In this perspective, we believe that the reform of hospital governance could come into its own and lead to sources of innovation, if the public hospital was administrated by a council possessing real authority, by independent administrators, following the example of PSPH.

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