Renewing governance modes and transforming professions and systems: example of healthcare systems

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Summary: Based on the example of the introduction of clinical governance intended to improve healthcare system performance, this paper proposes a theoretical analysis of the impact of managerialization of governance modes on transformation of systems and professions. It rests on a critical analysis of multidisciplinary works reflecting different research traditions, adding to the debate. This analysis leads us to go beyond the debate over control versus autonomy: we suggest that is more useful to examine the potential of clinical governance as a lever of the transformation of relations between actors and knowledge of action. This brings us to focus on some important learning issues.
**INTRODUCTION:**

Facing a welfare state crisis, since the early 1990s Western countries have tried to introduce reforms in the public sector to enhance the efficiency of the system. This reform movement is inspired notably by methods used in the private sector, and has engendered the “New Public Management-NPM” ideology. Manifested in several forms (Ferlie *et al.*, 1996), NPM seeks to mobilize levers (change of culture, decentralization of structures, incentives, etc.) to better respond to the needs of the population, while optimizing resources’ use. The renewal of professionals’ regulation modes represents a crucial issue, given their pivotal role in the provision of public services, and their influence on system performance. For instance, professionals are being criticized for trying to profit from the public system, sometimes to the detriment of responding to the population’s needs (Saks (1995, cited in Evetts, 2011)). Nonetheless, transformation of professional practices is reputedly difficult. Therefore, the study of the dynamics created by the introduction of managerial logic in the healthcare sector is particularly interesting because it fundamentally changes the regulation modes of the medical profession and has thus sparked great controversy. Managerialization of healthcare system governance is justified notably by the limits of professional regulation, namely 1) the relative inefficiency of control, which rests mainly on peer assessment, which in turn gives organizations little power to face situations of professional incompetence or breaches of ethics; 2) the fact that professionals place great importance on individual needs to the detriment of those of the population; 3) diverging of practices between physicians, which are not explained by a variation in health services needs (ref.); 4) gaps in the transfer of scientific evidence to practice settings. These limits of professional regulation create problems of inefficiency and undermine the quality of care.

In recent years, the concept of clinical governance, resulting from the NPM ideology, has emerged as a possible option in reform projects. Clinical governance is an “umbrella” concept that covers a set of management principles and tools (Department of Health, 1998): 1) standardization of professional practices; 2) actors’ accountability; 3) continuous quality improvement programs; and 4) involvement of professionals and users in governance. Clinical governance is intended to create synergy between two forms of regulation: bureaucratic and professional. This corresponds to the “ideal” model of
management of professionals proposed by Scott (1982), which grants equal power to administrators and professionals, and which recognizes the legitimacy of possible tensions between their operating logics. In other words, clinical governance is intended to create more complete organizations as defined by Brunsson (2000), by reinforcing local identity, hierarchy and rationality. Indeed, this “reform” tries to reinforce some features of identity: healthcare organizations are asked to define their environments (for example, health needs of the population served) and their boundaries. Because constructing an identity also means “being special,” healthcare organizations must formulate their own particular objectives, for instance in terms of quality improvement. The consolidation of identity is concomitant with greater local autonomy.

Installing hierarchy involves increasing coordination and control. Accordingly, healthcare professionals should develop teamwork and be guided by organizational policies rather than by professional norms exclusively. The team is collectively accountable for its performance. Reinforcing control also implies work standardization. Finally, organizations are expected to become more rational by setting objectives, evaluating action alternatives, measuring results and allocating responsibility.

As described above, the new governance model overturns traditional regulation modes at several levels. Professionals and administrators must now share responsibility for governance. For professionals, this entails reporting to stakeholders outside their profession. Professionals must also develop a more systemic vision of global performance, which goes beyond the performance criteria of their profession. The goal of clinical governance is to involve “ordinary” clinicians in managing the quality of care. It is no longer the professional elite that have the sole privilege of orienting practices. This rationalization project is also intended to “collectivize” practices in attempts to influence them by setting standards that are not defined exclusively by members of the profession, but also by regulatory bodies (e.g. quality board).

If this evolution toward more complete organizations has been received enthusiastically by those who believe that it allows the system to go beyond the status quo, it has also been strongly criticized by analysts who fear the negative effects induced by the perception of a questioning of the principles of “professionalism. This paper contributes
to this debate. Rather than taking a position, we analyze, based on a critical examination of multidisciplinary works reflecting various research traditions (European and North American), the potential of clinical governance as a lever of transformation of systems and practices. In this sense, our point of view is more managerial than sociological. We contend, inspired by the axiomatic theory of collective action, that it would be useful, as part of this debate, to transcend the dialectic of autonomy versus control to focus on the transformation of relations between actors and knowledge of action. Although the implementation of clinical governance dates back several years, at least in the context of the NHS, reigniting this debate is worthwhile for two reasons. First, it will fuel decision-making in countries that are currently questioning the renewal of physicians’ regulatory mode (Baker and Denis, 2011). Second, it can enrich the reflection of NHS decision makers regarding the anchoring conditions of the new governance model, given the evidence that implementation of this model has been very partial (Gask et al., 2008).

The text is organized as follows:

- In a brief review of the context, we highlight the positions taken on this movement. This section concludes by identifying the questions that are central to the debate.
- In the second section, we analyze these questions in light of the empirical literature analyzing the impact of renewal of professional regulation modes.
- In the third section we evaluate the potential of clinical governance as a new regime of governmentality, in terms of transformation of relations and knowledge. Learning issues are emphasized.

I. CONTEXT: CONTROVERSY AROUND CLINICAL GOVERNANCE

The concept of clinical governance was introduced in 1998 by the British government as part of its strategy to improve healthcare quality. This approach rests on yet transcends classic quality management techniques such as risk management (Buetow and Roland, 1999 cited in Roland et al. (2001). For instance, clinical governance is part of a national program to formulate standards of practices and provide professional training. It also emphasizes clinical leadership, particularly accountability.

The British experience has inspired many Western countries (notably France and Canada), and clinical governance is becoming increasingly prevalent in the reform
discourse. Nonetheless, years after its introduction, clinical governance is still controversial; the debate has crystallized around three positions:

A fairly positive position that sees clinical governance as a means of attaining excellence by creating synergy among four levels of care (individual, team, organization and system) (Brault et al., 2008).

For Denis and Contandriopoulos (2008), exercising clinical governance by putting in place several levers (incentives, information, authority, codes of ethics), can compensate for a deficit of governance, namely by increasing knowledge of what is produced, the consequences of actions and ultimately the benefits of a more concerted action, while “recognizing that there is an irreducible core of uncertainty that justifies the use of professionals’ expertise and skills in the management of health related problems” (our translation, p. 259).

These authors echo Moisdon (2008), who contends that problems of managing healthcare institutions arise not from information asymmetry, but rather from symmetry of non-information, at least at the organizational level. Healthcare organizations are very particular production systems (Moisdon, 2008): “physicians are focused on their own patient; they “design the production process” but no operations’ planning follows. The resulting organization is largely based on mutual adjustments; therefore no one truly manages singularity at the large scale” (our translation, p. 408). This is translated by problems of coordination, which affect the efficiency and quality of care. As a positive result, clinical governance should introduce a new form of rationalization, attacking the core of clinical activity, whose object of analysis is the patient trajectory.

A somewhat critical position. Several analysts justify their critical position by the risks or limits associated with this “new” model of governance.

- Authors such as Harrison (2004) maintain that the managerialization of governance will give rise to a new form of bureaucracy, owing to the proliferation of measurement and rules. Beyond bureaucratization, perverse effects may occur (shifting of goals, rigidity). As Broadbent and Laughlin (2002) assert: one possibility is that the areas which are given visibility and which are controlled by implementation of NPM-driven changes might well undermine the other aspects of the tasks, which are at the same time rendered invisible. In this way the whole
nature of the professional activities could be changed. Clinicians have also noticed possible [je ne pense pas que c’est nécessaire. On ne peut pas constater des impossible effects] perverse effects (Exwhorty et col., 2003).

- Broadbent and Laughlin (2002), and Harrison (2004), among others, have underscored the consequences of the questioning of the principle of trust in professionals. Power (1997, cited in McGivern and Ferlie, 2007, p. 1363) maintains that “trust in public sector professionals has been replaced by trust in accounting and audit.” Audit is presented as objective and neutral, but audit is not neutral but rather an active process of making things auditable. It colonizes and socially constructs environments so that people believe they can and should be measured and audited, undermining the legitimacy of practices less amenable to measurement. Fundamentally, the creation of such systems may therefore be self-defeating in political terms, they communicate to citizens that doctors and the care that they provide at public expense are not to be trusted (Harrison, 2004, p. 58).

- Some authors highlight limits of this approach of governance, which is normative and prescriptive, to deal with the hurly burly of everyday practice (Bilson and White, 2004; Harrison, 2004): all aspects of practice, including the normative rules themselves, need to be open to revision in the face of contingencies and ethical dilemmas of practice (p. 105). This criticism refers, some say, to the limits of evidence-based medicine, which presumes well-specified problems for which there is an adequate answer. The complexity of some clinical profiles (e.g. conjunction of problems), as is the case for patients treated in intensive care units (Hellou, 2008), raises serious questions about the pertinence of standardization of practices, these authors argue.

- The lack of consideration of the complexity of the system may favor “black box” reasoning by regulatory bodies, resulting from the standardization of practices (Harrison, 2004).

- Some studies conducted in the NHS context (Hackett et al., 1999; Degeling et al., 2004) also illustrate the lack of receptiveness of clinical physicians to this approach. Not only are they indifferent to the expected impact, but they also
consider that clinical governance represents managerial intrusion, which lacks potential in terms of improvement of care. These attitudes imply a serious problem of resistance to change (Hackett et al., 1999).

Lastly, authors like Harrison and Ahmad (2000) underline that “the explicit attempt of clinical governance to privilege science and destabilise professionalism risks repoliticising the previously depoliticised” (Reed, 1994 cited in Harrison and Ahmad (2000), given that clinical decisions made within the limits of a biomedical model are a politically invisible medium for health care rationing. Part of the durability of clinical autonomy lay in the advantages it offered to profession, government and patient; the impact of depprofessionalization on the legitimacy of the welfare state and ultimately the state itself is an open question.

A nuanced position: Proponents of this position consider that clinical governance is both an opportunity in terms of development of knowledge and expertise and a threat because of the risks of perverse effects produced by quantified performance objectives (Evett, 2011). Other analysts (Roland et al., 2001), without rejecting the governance model, raise questions regarding its implementation in some care contexts. They argue that primary care structures do not carry with them the direct managerial lines of accountability that are found in the hospital sector. Therefore the tension between the desire of doctors to be self-regulating professionals and the aim of government to manage the system to eliminate poor care is likely to be particularly acute in primary care (p. 192).

To summarize, these positions center on two types of questioning: 1) adoption of this governance approach by physicians—perceptions of the risks of loss of professional autonomy strongly determine resistance behaviors; 2) the potential of the clinical governance approach to transform professional practices effectively; the question being the extent that this governance model favors integration of physicians in the healthcare system, while preserving the advantages of the system such as capturing the complexity of clinical work. The integration of physicians refers first to alignment between the objectives pursued by the healthcare system and those adopted by physicians, and second to the appropriation of a set of organizational conditions that integrate physicians in the care improvement process.
II. INTRODUCTION OF A MANAGERIAL LOGIC: HOW WILL THIS AFFECT PROFESSIONAL AUTONOMY AND MEDICAL PRACTICES?

Despite the diverse nature of the impact of managerialization of the governance of healthcare systems, depending on its form (i.e. a hard or soft form of managerialization) (Ferlie and Geraghty, 2005) and the institutional context (Leicht et al., 2009; Kirpatrick et al., 2009), lessons can be drawn about the impact of this managerialization on professional autonomy and on the transformation of practices. Rather than describing these effects in detail, we begin by questioning the assumption of the links between managerialization (understood here as a reinforcement of the hierarchy, rationality and the organizational identity) and loss of autonomy. Second, we discuss the transformation potential of professional practices in light of the scientific literature.

*Does managerialization of governance of healthcare systems threaten professional autonomy?*

Despite alarmist discourse, empirical studies have not confirmed the prognoses of the deprofessionalization of medicine. For one, reinforcement of the hierarchy through consolidation of the organization function is not automatically translated by a loss of professional autonomy. As early as 1960, sociologist Hughes (1960) argued that professionals working in large organizations had greater autonomy than those working independently because they were able to protect themselves from pressure exerted by the clientele. Similarly, an in-depth analysis of the functioning of professional bureaucracies shows that professionals protect themselves from intrusion by management by controlling their work through formation of encapsulated organizations: by invoking possession of specific expertise, professionals in a dominant position ensure that professional expertise continues to define care processes (Ackroyd, 1996). This refers to the concept of double closure, that is the process whereby the medical profession attempts to maintain its power by combining two control mechanisms: external (on the market) and internal (in organizations).

Further, greater involvement of physicians in management functions has not led to a loss of professional autonomy. Kitchener’s (2000) study in the NHS context, following the creation of quasi-markets shows that clinical directors maintain the occupational closure of the medical domain. In fact, the assessment of medical practices remains the preserve
of peers. Fitzgerald and Ferlie (2000), who also analyzed the impact of the introduction of quasi-markets in the NHS, illustrate how the development of hybrid roles is a strategy physicians use to maintain self-regulation. Drawing on their clinical knowledge and implementation of subtle management processes based on a philosophy of collegiality, clinical directors have successfully reaffirmed the self-regulation principle. Once again, these studies confirm that stratification phenomena, through reinforcement of the role of administrative élites, can ensure the dominance of a profession in that it can protect it from environmental pressures (Freidson, 1985).

Therefore, these studies imply that management is far from posing a threat to professionals. In particular contexts, it may even be a resource to reinforce the power of physicians, as Kirpatrick et al. (2011) assert. They describe struggles between professions to assume managerial responsibilities.

Overall, apprehensions over the rejection of clinical governance because of a perceived loss of autonomy must be put into perspective. Empirical studies seem to demonstrate that more often than not, clinicians have preserved their professional autonomy (Kitchener et al., 2004). Professionals do not necessarily defend the status quo. Rather they deploy dynamic strategies that influence both the forms of professionalism and the organizations in which they evolve (Muzio and Kirpatrick, 2011). Suddaby and Viale (2011) recently formalized mechanisms used by professionals to maintain or transform institutions.

The real question is therefore whether managerialization of governance transforms medical practices in the sense of greater integration of physicians in the healthcare system.

**How does managerialization of governance of healthcare systems transform medical practices?**

**Difficulty changing practices:**

Several empirical studies underline the difficulties of anchoring managerial techniques in professional settings, particularly in the healthcare system (Ackroyd et al., 2007). Two main interpretations have been put forth to explain the difficulties:

- Neo-institutionalist theories shed interesting light on this topic. They focus on the influence of institutions, specifically cognitive, regulating and normative
structures that give meaning and stability to social behaviors (Scott, 1995). The idea underlying institutional theories is actors’ behaviors are motivated more by the quest for legitimacy than by efficiency. This explains the “homogeneity” of organizational structures in an institutional field, corresponding to the phenomenon of isomorphism (Di Maggio and Powell, 1983), which limits adaptation and innovation. Change occurs, at least according to some authors (Hinings and Greenwood, 1993), rarely and generally radically, and is translated by replacement of one archetype by another that becomes more legitimate. The concept of archetype refers to the idea that organizational structures are characterized by coherence and are underpinned by interpretive schemas and values. Changing archetypes is difficult in professional bureaucracies because professional practices are anchored in complex systems of interdependence, which creates great inertia at these organizations (Lamothe and Dufour, 2006).

For example, it is very difficult for healthcare professionals, including physicians, to change coordination mechanisms in management processes, given that these mechanisms are intimately linked to actors’ perception of the complexity of needs, a perception that is built over time and that is thus difficult to modify.

Managerial innovations raise more complex issues of implementation because of the gap between the implicit assumptions associated with managerial techniques and the characteristics of professional bureaucracies (Lozeau et al., 2002). For example, managerial innovations generally require better coordination between the functions of the organization, which is far from evident in bureaucracies that are loosely coupled organizational structures. Similarly, the introduction of a managerial vision potentially clashes with professional logics, given that traditionally, the legitimacy of change has been based almost strictly on criteria of prestige and the technical quality of services provided (Rueff and Scott, 1998).

As a result of these factors, managerialization attempts have often yielded disappointing results. Lozeau et al. (2002) mention the corruption of these techniques. They suggest that there is a greater likelihood that formalized techniques will be captured by and integrated into existing organizational dynamics (corruption of the technique) than that
the technique will change these dynamics in a way consistent with its objectives (transformation of the organization). This finding is particularly applicable to the implementation of quality management in healthcare organizations: it is primarily an administrative ritual that does not question the power structures. Further, it does not call for greater involvement of physicians in the processes. Other authors refer to a phenomenon of sedimentation (diverse sets of beliefs and values are embedded in organization structures and processes). By analyzing the case of a merger of university hospitals in the USA, Kitchener (2002) shows that this merger culminates in a phenomenon of sedimentation (Cooper et al., 1996), which is translated by specific behaviors: buffering (e.g. some units are protected from the merger) and loose coupling (gradual disappearance of the logic of functioning by program). These phenomena create unstable structures that, Kitchener argues, clearly demonstrate “disappointing outcomes” of managerial innovations. Sedimentation arising from the introduction of managerial logics has been confirmed in other studies. McNulty and Ferlie (2004) notably demonstrated the mitigated results of attempts at process reengineering in hospitals: managers and professionals acted in ways that supported the preservation of existing functional organizing arrangements at the expense of new process-based ways of organizing (p. 1405). The medical affairs department was the least interested in process reengineering, being focused the most on development of specialties. McGivern and Ferlie (2007) reported the playing of “tick-box games” following the introduction of medical audit in the NHS: several professionals pretended to be “accountable” while maintaining traditional practice modes. Concretely, consultants recorded data selectively and favored informal approaches. The two authors proposed a psychoanalytical interpretation of these behaviors, namely that “clinical audit is a mock ritual that provides the impression of regulation, which occurs as defences against anxiety, conflict and blame” (p. 1382).

Change in medical practices: beyond pessimistic discourse

If, as shown above, several works convey a rather pessimistic vision of the transformation potential of medical practices related to managerialization of governance, others offer a quite different vision. For example, Waring and Currie (2009) show that in
some contexts “doctors can themselves become managerialized as they stave off managerial encroachment.” They find that physicians appropriated knowledge management tools to improve the quality of care, by deploying a strategy that limits control exerted by management. Similarly, Levay and Waks (2009) describe a form of soft autonomy. To preserve their legitimacy, procure resources, and improve care, physicians in the Swedish healthcare system agreed to exhibit transparency: quality registers (containing anonymous data) now give nonprofessionals access to vital information on medical practices. Nonetheless, the physicians ensured, by negotiating with nonprofessionals, that they control the criteria on which they are assessed. Bejerot and Hasselbladh (2011) propose an interesting reading of the process that engendered this transformation. It is notably through a productive form of power (pastoral power) that professionals were gradually led to accept new forms of regulation. This subtle form of power invites and encourages subjects to participate in building the arrangements that will govern their conduct. Concretely, this transformation (of a register controlled by the profession to a tool controlled by government) has occurred in a series of small steps, notably using persuasion and incentives, as part of a general quality management strategy. In this case, the politicians and the public did not need to be convinced (Bejerot and Hasselbladh, 2011): the initiators of the project simply needed to convince some physicians, particularly those interested in a “more rational” approach to assessment of care quality. If the Swedish context favors such dynamics (because of the lack of a tradition of corporatist positioning, for example), this study nonetheless shows that collective construction of a form of rationalization, involving physicians, may result in doctors’ “no longer [being] in control of their commitment, of the purposes that serve to shape and direct their collective competencies. The established professional regime, until recently uncontested in its authority over medical practice, is silently dying”

In light of these findings, it appears that changes in medical practices, intended to heighten integration of physicians in the healthcare system, are indeed difficult but are possible in some contexts. Further, changes will not necessarily be achieved radically, as neo-institutional theory suggests. Thus, actor agency can bring about gradual change in the rules of the game.
In addition, rationalization of collective action implemented by the State (for example, the design of practice assessment mechanisms; see Bejerot and Hasselbladh (2011)), plays a crucial role. This confirms once again that “the arenas of professional neutrality and autonomy are transformed not as a product of changing occupational strategies as Abbot would have it, not as an effect of technical change, as suggested by Freidson, but as a result of changing government objectives and policies” (Johnson, 1995 p. 20). Johnson (1995) therefore invites us to transcend the dichotomy of intervention and autonomy: autonomy as an outcome of political processes far from being reduced by state intervention is a production of governmentality that brings the state into being (p. 22). Governmentality, a concept introduced by Foucault (1994), refers to government practices, mechanisms through which the State practices its art of government (conduct of conducts): concretely, governmentality is the procedures, techniques, mechanisms, institutions and knowledge that collectively empower political programs (Johnson, 1994, p.12.).

Below, we analyze the possible impact of the movement associated with the concept of clinical governance, conceived as a new regime of governmentality. We do not attempt to predict the “outcomes” of the movement, but rather discuss the issues related to the transformation of practices. We believe it is difficult to project the trajectory of instruments because they produce their own effects, as illustrated by Moisdon’s analysis of the history of the regulation of the French hospital system (2007). In this sense, our position differs from that of Evett (2011), who expresses a less deterministic vision.

III. DISCUSSION OF THE POTENTIAL OF CLINICAL GOVERNANCE IN TERMS OF TRANSFORMATION OF MEDICAL PRACTICES

III.1 Clinical governance: why we need to transcend the debate over control versus autonomy

We have seen that the controversy around clinical governance centers largely on the tension between authority and autonomy. Beyond the fact that empirical studies greatly relativize this threat, the debate could be enriched by recognizing the distinction between clinical and specialized expertise introduced by Dodier (1993). The first concept refers to
the expertise of clinicians, their skills, and the private reflective space in which decisions take shape. The second concept corresponds to external references (rules, objects, words) in short all mechanisms that experts present to support their opinions. Going beyond the control/autonomy dichotomy is consequently possible if the implementation of clinical governance: 1) takes into consideration the singularity and complexity of cases, both of which are sources of uncertainty and give rise to what some call “prudential activity” (Champy, 2009), which therefore necessitates clinical expertise; 2) “favoring a technical arena centered on opening black boxes” (our translation of Dodier, 1993). The development of specialized expertise, in conjunction with the reinforcement of accountability would allow management of professional activities. This management is not limited to standardizing practices. As we will see, it aims to change the relations among actors, and especially to reinforce the integration of physicians in the healthcare system and thereby introduce new dynamics of knowledge. The impact of “control” on physicians’ professional autonomy will be manifested more at the meso (e.g. assessment of medical practices at an aggregate level), and macro (e.g. supremacy of the biomedical model) levels. Autonomy at the micro level, that is autonomy in work, would be preserved. Under these conditions, the implementation of clinical governance would not necessarily bring about a transfer of power from professionals to management (Champy, 2009). Nonetheless, clinical governance requires the adoption and implementation of particular rationalization modes, which we will discuss below.

II.2 Clinical governance: an action regime that favors the evolution of relations and knowledge?

As a new form of governmentality, clinical governance proposes a new action regime that we will analyze with reference to the work of Hatchuel (2000), who, from a Foucauldian perspective, proposes an axiomatic theory of collective action. Hatchuel (2000) rejects the idea that collective action can be reduced to a principle (such as cost control versus quality of care) or a totalizing subject (e.g. physician versus administration). He argues against consideration of action as a naturally observable phenomenon; rather it should be viewed as a change in the world that must be conceived. Two operators of conception are thus formalized: the “knowledge” operator and the “relations” operator. To understand
collective action, a principle is formalized: inseparability of knowledge and relations, which essentially challenges the autonomy of knowledge relative to relations and denies the possibility of recognizing relations, independently of knowledge held. Therefore, Hatchuel points out that there are only two possible movements for collective action: reconstructing compatible relations by modifying knowledge and reconstructing compatible knowledge by modifying relations. It is through prescriptive relations, associated with rationalization modes, that knowledge and relations between actors influence one another. These learning processes occasionally involve new actors, who bear new knowledge of action. The movement of collective action is also made possible by catalysts of action, namely rational myths. They are limited conceptions of the world and of others that favor collective action dynamics because they express innovative knowledge and therefore new possible relations between actors.

Applied to the analysis of clinical governance, this theoretical vision leads us to conceive this new regime of governmentality as one that bears a rational myth, namely a pluralistic model of governance of healthcare systems, centered on performance management. This mythical dimension lets us transcend the controversies, some of which are not well-founded, and work on the innovation potential of this rational myth: a model is inherently neither good nor bad. By nature, it carries a reductive vision. To become concrete, the transformation potential of practices involves a process of contextualization, which consists in constructing in action new relations between actors and new knowledge of action. The true question is then whether this new regime of governmentality favors these dynamics. Concretely, we must ask to what extent does clinical governance reinforce the interdependence among actors on the horizontal (between care providers) and vertical (between production organizations and regulatory bodies) planes? If interdependence at the horizontal level is fairly perceptible by physicians, at least regarding clienteles with more complex needs, perceiving interdependence at the vertical level is a real challenge. Not all physicians realize that the preservation of their practice autonomy requires greater management of interdependence, to influence the allocation of resources (ref.). Nonetheless, the reinforcement of this interdependence would affect relations between physicians and other actors in the system, as mentioned above. The challenge here is to reinforce the integration of physicians in the healthcare system. This is translated by
greater inter-professional cooperation to improve the quality of care (i.e. horizontal interdependence) and by sharing of responsibility for system governance (i.e. vertical interdependence).

In line with Hatchuel’s theory, this evolution of relations would necessitate an evolution of knowledge of action. The challenge of this collective learning is to articulate two logics: a professional logic (attached to the following “norms”: quality of care, patient-centered approach, development of expertise, etc.) and an organizational logic (attached to the “norms” of coordination, efficiency, etc.). A recent study by Reay and Hinings (2009) shows that this reconciliation of logics is possible when the actors collaborate, which leads them to innovate in their approaches.

**II.3 CLINICAL GOVERNANCE: LEARNING CHALLENGES**

Our analysis of the transformation of professional practices leads us to highlight the following four learning issues:

*Development of knowledge that takes into account the complex nature of clinical activities*

We posited that the integration of physicians in the healthcare system requires the development of new knowledge, which can reinforce interdependence among actors. One of the major challenges of this learning concerns the development of legitimate and credible forms of standardization. The legitimacy of the bureaucracy thus rests on the knowledge underlying the rules (Weber, 1930). As we have seen, several analysts question the possibility of standardizing medical practices, owing to the complexity of the medical practice. If this complexity is undeniable, a form of standardization is nonetheless necessary to enhance the quality of care: empirical studies clearly demonstrate that care quality does not result uniquely from individual competency; it also requires organizational intervention, which includes the use of practical guides (Baker, 2008). These guides are useful in a context of accelerated knowledge development. The question is therefore not whether standardization is possible, but rather what is the most effective form of standardization given the complexity of clinical activities. Currently, much remains to be done in the development of practice guides that take the complexity of clinical profiles into account, particularly multimorbidity (Boyd and Fortin, 2010). Indeed, the prevalence of multiple chronic diseases is far from negligible: approximately
one-quarter of adults suffers from more than two chronic diseases, and this rate increases with age. The management of such profiles is particularly complex because of possible interactions between clinical conditions. Thus, the use of practice guides, traditionally formulated for one illness, becomes (Boyd and Fortin, 2010) questionable and even dangerous (for example because of interactions among drugs). One study even confirms that the practice guides generally recommended by national and international organizations for the treatment of nine chronic diseases do not take into consideration the complexity of clinical profiles (Boyd and Fortin, 2010). Consequently, the development of “pertinent” practice guides (and therefore performance indicators) represents a major learning challenge, if the aim is to encourage their appropriation by physicians and to improve the quality of care. The development of new knowledge is thus an important success factor of change in medical practices. Such a development could articulate the professional (patient-centered care approach) and organizational (control over care quality) logics. In addition to the merits of reviewing the content of practice guides, it is important to ensure that the usage modes of these practice guides are consistent with the complex nature of clinical activities. In other words, these guides would serve more as aids to enhance decision-making and accountability, and thus refer to specialized expertise. The challenge would be to ensure that they are not substituted for clinical expertise.

Mechanisms to allow collectivization of the learning process

The Swedish experience shows that physician participation in the learning process can greatly favor the transformation of their practices. If, as mentioned, the medical profession is embarking in some contexts on these learning dynamics through “managerialization,” it is doing so in isolation (Waring and Currie, 2009), to deter intrusions from administration. These actor dynamics will probably engender non-negligible learning. Nonetheless, we can question the potential of these dynamics in terms of collective learning, required to better respond to the increasingly complex needs of the clientele. The challenge is therefore to ensure that physicians participate in devices allowing coordination of the learning of several interdependent actors: the medical
profession, other professions (at different levels of the healthcare system) and the administrative sphere.

If it is true that physicians’ “political behaviors” may hinder this participation, some studies indicate that crisis situations, particularly crises of knowledge, can facilitate the emergence of new dynamics (Rochet et al., 2008); because these situations necessitate reinvention of the rules of action. Lenay (2008) shows how a crisis in the management of some chronic diseases in France, which underlines the interdependence between care providers and the inadequacy of financing modes, has led to the creation of a learning process centered on a new object of governance: patient trajectories. Such an object induces a more collective learning process, notably intended to convince physicians that development of knowledge related to patient management is not solely the responsibility of physicians.

Tools supporting coordination of learning

Beyond the challenge of developing new knowledge of action in the institutional field, it is important to support learning at the local level. Accordingly, the use of “tools” to coordinate the learning of interdependent actors is essential, given that collective learning requires prescriptive relations. The development of clinical-administrative learning tools, is therefore an important challenge, notably for performance management. We have previously presented a concrete example of a performance assessment tool that allows cross-learning among healthcare production organizations and regulatory bodies (Touati et al., submitted). Concretely, this tool takes into account the complexity of healthcare organizations and can thus favor constructive dialogue among clinicians, particularly physicians and administrators. The tool in question has the advantage of considering different dimensions of performance, referring to the four functions of viable organizations: 1) goal attainment (efficiency, effectiveness and user satisfaction), 2) the production function (coordination of production factors to ensure the productivity of resources, quality of care, etc.), adaptation to the environment (consideration of opportunities and threats: response to the needs of the population, ability to mobilize the community, etc.) and maintenance of values (cohesion, organizational climate). This vision of performance establishes links between different dimensions of performance.
The tool therefore responds to a particular logic of design and use because the indicators are grouped by dimension of performance and the tool is used to support reflexivity in performance evaluation. Rather than comparing the indicators with standards and objectives, it is a more question of making sense of the data: the different stakeholders have to analyze performance by exploring areas of possible explanations referring to alignment issues: strategic alignment (coherence among the functions of goal attainment and adaptation), tactical alignment (coherence among the functions of goal attainment and production); operational alignment (coherence between the adaptation function and maintenance of production values); allocative alignment (coherence between functions of adaptation and production) and legitimacy alignment (coherence among the functions of goal attainment and maintenance of values). Because this performance assessment tool clarifies performance management issues, it is comparable to a learning tool, i.e. a tool that supports reasoning.

The use of such tools for development of learning also requires updating of information systems, which were traditionally designed for administrative control purposes. The goal is now to ensure that the information systems allow the analysis of system performance, and take into consideration the care trajectory and the clinical profiles of clientele.

The creation of a real impact on practices must not be limited to the putting in place of tools. The mechanisms must be integrated in daily activities, particularly by drawing on the important role of some new actors.

*Legitimate new actors that bear new knowledge*

The implementation of this new regime of governmentality represents a major change wherein new actors who can “sell” this change and especially guide the learning process play an important role. These new actors are simultaneously products and vectors of this learning process. Specifically, we suggest that the complexity of the learning process and political issues should create a need for a constellation of new actors, combining several sources of influence and expertise. Our reading of the issues, based on an analysis of empirical works, leads us to envision key roles for

- medical directors, who have a hybrid role (clinical and managerial): these actors are important in the field because of their knowledge of the clinic, which grants
them legitimacy, and because of their ability to influence medical practice through collegial management (Fitzgerald and Ferlie, 2000)

- actors with skills related to the new object of governance (patient trajectory): this will probably entail development of new competencies regarding operations analysis and management (Moisdon, 2008)

- actors with technical skills (e.g. information system design): medicalization of information systems in France has for example given rise to a new function—Medical Information Director.

Coordination of the roles of the new actors represents an important challenge. Therefore, to encourage collective learning, several levers may be mobilized.

**CONCLUSION**

In this article we have gone beyond the controversy on clinical governance to examine the potential of this governance model. The regulatory modes of professionals must be reviewed, given the evidence of their limits. Beginning with the assumption that clinical governance is “uniquely” a rational myth, namely a driver of action, the real question is whether the implementation of this new form of governmentality can transform medical practices to better integrate physicians in the healthcare system. We are thus moving beyond the sterile debate of control versus autonomy. First, it has been empirically demonstrated that the managerialization of governance is not a threat to professional autonomy, at least at the micro level. Second, conceptually, it is useful to distinguish clinical expertise from specialized expertise, especially when designing rationalization modes.

With an axiomatic vision of collective action, we have focused on the transformation potential of relations between physicians and other actors in the healthcare system created by development of new knowledge of action, hence the value of examining learning issues. While highlighting the difficulty of changing medical practices, empirical evidence shows that this change is possible in contexts where rationalization modes of collective action are mobilized. Our analysis has led us to put forth hypotheses about the rationalization modes most likely to produce learning: 1) development of knowledge and therefore of rationalization modes that take into consideration the complex nature of
clinical activities; 2) devices that allow collectivization of the learning process; 3) tools to allow coordination of the learning of interdependent actors; and 4) legitimate new actors that bear new knowledge.

Further, we can assume that the effective impact of these rationalization modes on learning dynamics also requires coherence with several other elements of governance such as incentives, logics of accountability, and change conduct. First, one must ensure that the incentives offered to physicians lead them to integrate an organizational logic. Evidence militates in favor of collective incentives that take into consideration the interdependence of actors and that are more “effective” in terms of performance improvement (Fisher et al., 2006). Second, implementation of a logic of learning also requires a change in the logic of accountability. If clinical governance requires physicians to be more accountable, these accounts should not be confused with strict control over the attainment of objectives. It should also encourage dialogue about constraints and areas of improvement. Third, promotion of dynamics of learning would also imply increasing the stability of the system, and therefore reducing the number of reform projects, to allow the actors concerned to appropriate the changes. Lastly, even if this seems self-evident, it is crucial to involve physicians, at least those who are most interested, in designing concrete governance modes.

Our analysis of clinical governance, which emphasizes learning issues, does not project an idealistic vision of the world that ignores power struggles. Political issues are indeed present, yet evolution of knowledge of action can change the rules of the game and therefore the power relations. To summarize, the real challenge of implementation of clinical governance is, in Foucault’s words (cited in Hatchuel, 2005) to see how to disconnect the growth of our capacities from the intensification of power relations” (our translation, p. 23).

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