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Structuring ambiguity in hospital governance

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Summary

This empirical, multicase research into developing governance structures highlights the strategies of four Dutch hospitals to strengthen their governability. The hospitals studied choose to commit themselves to duality as their starting point for structuring governance arrangements. All of them create positions of doctors and managers that are based on consensual decision making and common responsibility, in this way structuring governance at hospital level and unit level. Interestingly, they consciously choose to create ambiguous positions keeping formalization by rules and job descriptions low. Efficacy of dual hospital governance depends heavily on personal strength, mutual understanding, and trust of the incumbents, which offers new chances for governability but also harbors vulnerability to hospital governance.

KEYWORDS

decision-making arrangements, dual governance, Dutch hospitals, hospital governance, structuring

1 | INTRODUCTION

In many countries, hospitals are increasingly challenged to innovate their governance structure, which makes hospital governance a very relevant subject. Hospital governance is defined as a set of processes and tools related to decision making in steering the totality of institutional activity, influencing most major aspects of organizational behavior, and recognizing the complex relationships between multiple stakeholders.¹ However, hospital governance is a complex problem because of two intermingling dynamics: The first dynamic is internal and the second external.

Internal dynamics are rooted in the character of hospital organization as a professional organization—consisting of several interdependent but relatively autonomous groups—meeting the challenge to create workable and viable relations. For instance, Glouberman and Mintzberg distinguish four groups—doctors, nurses, managers, and supervisors

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representing the community—all contributing in their own specific way to hospital governance. Of these groups, managers and doctors generally are considered to be the dominant actors in hospital governance, with their own goals and decision-making structure but also their interdependence in producing healthcare.² Dual hospital governance, the coexistence of managerial and professional lines of authority,³ can be understood as a characteristic feature of hospital governance. In hospitals, decision making is not rooted in a single “governance chain,” the unified decision making and reporting structure we recognize in corporate governance.⁴ Particularly, traditional decision making in hospitals depends on consensus management by permanent consultations and negotiations between fundamentally different governance systems, each with its specific “institutional logic.”⁵ Decision making by management is built on hierarchy whereas doctors furnish some of their colleagues with responsibility by giving them mandate. Their governance systems differ fundamentally as managers practice top-down decision making whereas doctors typically take decisions bottom-up. The challenge of hospital governance is rooted in the “peaceful coexistence” of the two governance structures and, eventually, the integration of decision-making processes in the hospital.^{6,7}

The external dynamics of hospital governance result from governments and stakeholders' pressure to change hospital governance. Hospital governance is a matter not only of consulting and negotiating managers and doctors but also of the power of actors who act on different societal levels.^{1,8} Governments explicitly exercise power to radically transform hospital structure, which makes designing hospital governance arrangements essentially a triadic affair of doctors, management, and government. Many governments seek to create and empower general management in hospitals as a way to improve governability in the changing context of market-oriented reform. They intend to change hospital governance fundamentally by regulation,⁹ although changing governance relations can also be the consequence of less direct interventions, for instance, performance management.¹⁰

Among these governments, in the last 30 years, the Dutch government consistently has sought to improve hospital governability. Governability, defined as the overall capacity for governance of the hospital,¹¹ is expected to improve by putting management of hospitals unambiguously in the hands of professional managers explicitly wishing to get rid of the arena-like hospital governance system coupled with slow negotiating processes of autonomous parties. The government rejects dual governance as a viable way to improve hospital governability, stressing that modern hospital organizations operate in a market-oriented healthcare system, “two captains on the ship” hinders the hospital's ability to compete. The Dutch government's endeavor was, and still is, to establish the unambiguous nature of hospital governance.⁶ The model of the monolithic, or bureaucratic, hospital organization still is one of the cornerstones of regulation in healthcare.¹² So, in the continuing debate on hospital governance, we recognize two fundamentally different manners of improving governability. Meanwhile, the Dutch governmental policy on hospital governance to get rid of ambiguity by establishing “final responsibility” of general management has been consolidated by several laws.

Other countries experience a similar trend towards the replacement of dual hospital governance by general management. In the eyes of the proponents of general management in hospitals, consensus management can lead to the lowest common denominator decisions and to long delays in the decision-making process. Pollitt et al describe the hospital governance structure of the English healthcare system before the 1980s: The parties are involved in a diplomatic collaborative culture requiring much negotiation, flexibility, and creative ambiguity to reach consensus.¹³ Dual hospital governance was, and still is, not a very popular model among governments, health managers, and experts. Most views on hospital governance have chosen to combat duality of hospital governance in favor of governance structures in which dominance is assigned to a singular position, mostly general management, whereas some authors seek to improve governability by empowering physicians' self-governance.¹⁴ In all these views, dual hospital structure has to be prevented at any cost. However, by regulation of hospital governance, governments separate the powers that traditionally were involved in consensus decision making, which urges the designing of new connections between the parties.¹⁵

1.1 | Trends in hospital governance

Since governments launched their monolithic or bureaucratic¹ model favoring general management in several countries, hospital governance had to be innovated. Innovating governance was urged by the influential New Public

Management (NPM) movement. NPM sought to stimulate entrepreneurial hospital management by relying on quasi-market forces rather than planning and by introducing strong performance measurement and monitoring mechanisms.¹⁶ Performance management's focus was preponderantly on volume and cost control. However, in successive years, the agenda of politicians, policy makers, and managers has been broadened towards performance in terms of clinical outcomes like quality, safety, integrated care, and risk. In many countries, this is the main reason to co-opt doctors into managerial roles of the hospital.¹⁷ Medical managers (MMs) are reported to exert positive influence on prioritizing patient experience and quality improvement.¹⁸ The process of co-opting doctors in management gives rise to much research on professional-manager hybridization.^{19,20}

Although the involvement of doctors is growing in many countries, differences as to their positioning are substantial. For instance, in the England, medical management typically is being effectuated into doctor's membership of the Executive Board,^{21,22} whereas in the Netherlands, as we will see later, the term "medical management" also, and foremost, refers to the involvement of doctors in the management of medical departments or units. Differences between the positioning of doctors in hospital governance may be explained by the history of national governance systems and their path dependency²³ and also by the focused strategies of doctors and their associations regarding hospital management and their role in it. In Denmark, doctors show a less negative attitude towards hospital management than in the United Kingdom, regarding hospital management more or less as their "natural domain,"²³ and Dutch doctors and their association develop focused strategies to participate in hospital management.²⁴

2 | STRUCTURING HOSPITALS

Against the backdrop of conflicting models, there is a strong need for the creation of decision-making arrangements that foster coordination at different levels of the hospital structure and for theoretical insights that help us to understand the structuring of hospital governance.²⁵ This article describes and analyzes the institutionalization of new forms of coordination between doctors and managers and their consequences for governability of hospitals. In this article, we propose to study the structuring of hospital governance in the Dutch context. The research addresses the following questions: How are hospitals structuring decision-making arrangements and what are the consequences for the governability of hospitals?

This article intends to offer a contribution to the debate on viable arrangements that restructure coordination of managerial and medical governance systems, using the Netherlands as a case. The case highlights developing hospital governance in which decision-making structures are being redesigned by doctors and managers choosing the dual character of hospital organization as a starting point.

We studied the way hospitals structure their decision-making arrangements and the consequences for governability focusing on the concept of structuring. Structuring is the process of social creation of rules, roles, and relationships, which at best facilitates effective coordination and control.²⁶ In structuring their decision making, the hospitals make two choices on which we focused our research. The first choice concerns the fundamental organizing principles that guide the structuring of the hospital.⁵ The "logic" of an institutional arrangement gives an answer to the question how to balance different and competing values in the organization: What kind of organization will we be? For instance, an organization may prioritize the maximization of business-like performance and efficiency, or it may seek legally sound relationships summarized under the heading of "good governance" or democratic legitimacy in terms of participation of relevant groups. Actors participating in organization design have the options of competing logics. However, in practice, their choices will be trade-offs as organizations have to achieve the balance between desirable but incompatible features in finding the "best" structure.²⁷

The second choice is about structuring the hospital and to institutionalize behavioral control. Two parameters are crucial to behavioral control: the assignment of positions and roles to members and the degree of formalization. Positions and roles embrace the tasks and responsibilities often as a part of more or less detailed job descriptions. The degree of formalization is important as it determines the discretion of employees.²⁸ At the high end, organizations

exert control by means of detailed job descriptions, procedures, and extensive rules, more or less “preprogramming” their employees. At the low end, activities are seen as unique cases for which no tasks have been differentiated or procedures have been designed. In case of low formalization, behavioral control rests heavily on agreed mutual binding norms reflecting the actor’s capacity to self-control.²⁹

3 | METHODOLOGY

The study’s goal is to describe and analyze the dual hospital governance arrangements doctors and management create to organize their mutual dependency by structuring their relationship. The article is based on the PhD thesis by Linda Muijsers-Creemers who researches in depth the creation of coordinating arrangements by management and doctors in four Dutch hospitals.³⁰

The research is a multicase study comprising four general hospitals in different parts of the Netherlands. The research was preceded by a pilot that was held in a hospital in the western part of the Netherlands. Case selection was primarily based on pragmatic grounds. General hospitals that showed interest in the research, were ready to participate, and were willing to support the research financially were selected. Characteristics in terms of size (2015) and location of the participating hospitals are as follows:

- Hospital 1 is a 300-bed hospital in the northwest of the Netherlands.
- Hospital 2 has 565 beds in the southeast of the country.
- Hospital 3 is a 455-bed hospital in the eastern part of the Netherlands.
- Hospital 4 has 554 beds and is located in the western part of the country.

The study has a qualitative and explorative character. We conducted extensive fieldwork during 3 years, resulting in thick descriptions of the four cases using a mix of research methods.³¹ Analysis of documents, observations, and interviews were the main methods used with a heavy accent on interviews.

The total of interviews amounts to 105. All actors playing a relevant role in the dual arrangements were invited to participate in the research. The following groups and interviewees are included (some of them were interviewed more than once):

- MMs: 7;
- hospital managers (HMs, at micro-level): 16;
- CEOs including ex and interim: 14;
- members of the Board of Medical Specialists: 23;
- support staff (financial, human resource management [HRM], and public relation [PR]): 14;
- medical specialists: 7;
- lower managers, assistants-to-the-management, and others: 21;
- others (consultants): 3.

The in-depth interviews were semistructured, backed by topic lists based on documents and data derived from preceding interviews. Resources consist of local policy documents, relevant documents from the government and associations, and academic articles on the subject. Nonparticipatory observations of meetings of doctors and managers were performed to “feel” the practice of decision making.

To focus the study, decision-making processes that meet certain criteria were selected. The most important one was the degree in which the dual hospital structure was “active” and researchable. The decision-making processes

were expected to activate the relevant actors in order that their positions, role playing, and behavioral norms could be researched “in action.” Only processes were selected in which the governance problem played a part, doctors and managers were mutually dependent actors, and the subject was “big” enough or strategically relevant,³² for instance, the construction of a new hospital and defining a new strategy.

Data collection produced “thick descriptions” in order to display everyday practices of hospital governance of each case in rich detail.³³ The descriptions included the involved actors' positions and their roles and the way they structure their mutual dependence in decision-making processes at hospital level and unit level. Analysis was done by coding the data thematically following the central theme of the research. Quality of the research was enhanced by the researcher's relatively long sojourn in each case (about 6-7 mo in total) and regular revisits. Also, quality was strengthened by member checks with key personnel of participating hospitals (members of the Board of Directors, members of the Board of Medical Specialists, and others), the use of triangulation of three different research methods, and intensive and extensive discussions in the research team and with other university colleagues acting as peer reviewers.

4 | RESULTS

Doctors and managers in the four hospitals that were studied have chosen to improve governability along similar lines. They all embarked on structuring duality some years ago, as contrasted with the official model backed by law, defining the hospital as a monolithic organization headed by general management. Strikingly, local contexts of the hospitals in which the structuring of duality took place appeared quite similar. Two similarities of their local contexts are especially relevant.

First, antecedent to redesigning their decision-making arrangements, all hospitals in the study experienced crises at their “apex.” The crises ended in resignation of the Executive Board and the Board of Medical Specialists and the appointment of new members of both boards. The crises gave way to an approach to hospital governance that differs fundamentally from the official, monolithic model. This situation gave rise to intense debate between HMs and doctors about new decision-making institutions of the hospital. Although hospital management has been furnished with formal “final responsibility,” the four case hospitals depended on collaboration of doctors to improve governability. Here, we witness the mechanism of informal co-optation: hospital management formally empowered by law, experiencing the expert power of doctors, striving to absorb the threat to its legitimacy by offering the sharing of power.^{18,34}

Second, all four hospitals were implementing decentralization of hospital decision making in transferring responsibility to strategic business units (in Dutch, “Resultaat Verantwoordelijke Eenheden” [RVE]), largely based on single medical specialties. Generally, decentralization is regarded as legitimate as strengthening of discretion is welcomed by doctors and also by central managers as decentralization can, paradoxically, be understood as a source of additional power by the sharing responsibility, resulting in more instead of less power for management.³⁵

4.1 | Choosing the principle of duality

The hospitals in our research all chose to improve governability along similar lines. Their model embraces the following fundamental organizing principles³⁶:

- recognition of mutual dependence,
- juxtapositioning of hospital management and doctors in hospital governance,
- sharing of responsibility, and
- consensual decision making.

In the subsequent paragraphs, we will analyze the translation of these principles into decision-making arrangements, at (1) hospital level and (2) unit level. To guide our analysis, we summarize in Figure 1 the major decision-making arrangements our four hospitals have created.

The governance arrangements of our four cases, depicted in Figure 1, mirror the way they structure the interdependence of managers and doctors while both groups remain their autonomy. Taking the two silos as a starting point, the creation of positions at hospital level and unit level is key as they are crucial to decision making. The positions are depicted as “boundary-spanning” positions,³⁷ advanced positions acting on behalf of their silo and striving for consensual decision making. At hospital level, representatives of the Board of Medical Specialists and the Executive Board practice decision making on all relevant subjects, including hospital strategy. At unit level, representatives of unit management and medical unit do the same. MMs (in Dutch hospitals, the title “Medical Manager” is practiced only at unit level, as distinct from English hospitals) and nonmedical HMs together manage the unit.

Decision-making arrangements at unit level differ somewhat from hospital level. Decision making at hospital level is practiced within the context of a counsel, where representatives of both boards meet, displaying a certain minimum of regulation on scheduling the meetings and the roles of chairman and scribe. At unit level, the meetings mostly have not been scheduled, and the MM and HM generally are in touch and meet if necessary.

In the subsequent paragraphs, we will analyze the structuring of decision-making arrangements of the four cases at hospital level and unit level.

4.2 | Structuring at hospital level

In all four hospitals, the Executive Board and the Board of Medical Specialists restructured their relations. Reconstruction shows that the crises at hospital level enabled the actors to adopt a fundamentally different hospital governance model than before. After the crises, in all our hospitals, the Executive Boards and the Boards of Medical Specialists started to discuss and negotiate their relationship. Formulations, used in relevant documents, hinge upon equivalence: “juxtaposition of the Board of Medical Specialists concerning all problems at hospital level” (hospital 1), “equivalent partnership” (hospital 2), “governing the hospital together” (hospital 3), and “governance as good colleagues” (hospital 4). The “final responsibility” of the Executive Board has been redefined into something like the hospitals’ figurehead while dual hospital governance “upgrades” the Board of Medical Specialists—the representative of all doctors in the hospital—into a juxtaposed and virtually comanaging position at hospital level. However, as state laws define hospital governance monolithically in terms of “final responsibility” of the Executive Board, the position of the Board of Medical Specialists is described as an “advisory council” comparable with the Works Council and the Clients Council, both regulated by law.

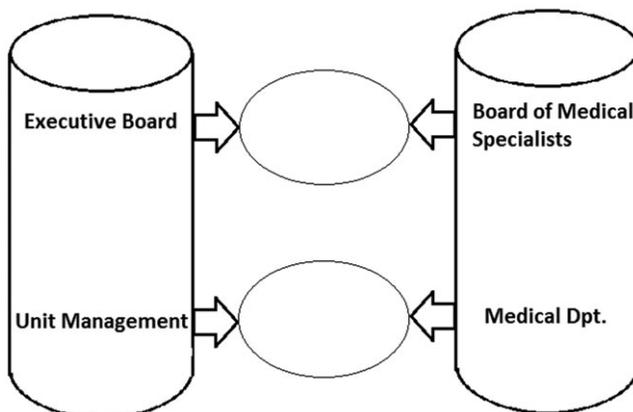


FIGURE 1 Boundary-spanning positions for decision making at hospital level and unit level

In retrospect, respondents who were involved in the creation of the, then, new decision-making arrangements stress the change of fundamental organizing principles. Some respondents experienced the, then, new approach as a turning point in hospital governance. As the former chair of the Board of Medical Specialists of hospital 3 remembers, expressing his or her relief:

The former Executive Board was more about fighting. This Board was striving for power and did not want to ask for our opinion which we (as members of the Board of Medical Specialists) sought to enforce. This was a permanent debate about power. Who is the boss?

A member of the Board of Medical Specialists of hospital 3 adds:

Well, although the Board of Medical Specialists is not a formal decision making institution (...) the only way to govern a hospital is by cooperation of the Executive Board and the Board of Medical Specialists and I venture to say this is indeed like that these last years.

The decision-making arrangements that management and doctors created at hospital level embody the “juxtaposed” positioning of the doctors in hospital governance.

4.2.1 | Formalization of positions and relations

An important feature of the decision-making arrangements at hospital level is the way formalization has been designed to effectuate behavioral control. Interestingly, decision-making arrangements at hospital level lack further specification of tasks and responsibilities. Respondents stress the relevance of joint action and doing things together as much as possible. Hospital doctors express strongly held norms about how the Executive Board is expected to behave. The Board of Medical Specialists of hospital 2 explains:

Well, look, if there is a meeting at Monday morning, then this meeting is held also dually. So, if there is something with pediatrics, a meeting will be held with the Medical Manager. But every possible effort will be made that the member of the Executive Board does it together with the member of the Board of Medical Specialists. (...) And this is not because of failing trust. It is because we think we both have our angle (...). Also, if we tell to the organization duality is important then we ourselves have to do it. So, we also serve as a model.

In dual hospital governance, the position of board members is ambiguous. Members of the Board of Medical Specialists are fully aware that they have to combine two roles, being the equivalent partner of the Executive Board and representative of the rank and file of medical specialists. A chair of the Board of Medical Specialists (hospital 4) summarizes his or her position and roles:

... as we have an intelligent and competent Executive Board with the same goals we can go on very well together while we respect each other's position I still am the representative of the medical specialists and not the Executive Board, so my responsibility differs from theirs. But for that reason one can do interesting things.

The two roles of representative and partner are hard to combine, but practice is not guided by much formalization by rules and regulations. In official documents, only the common responsibility of both boards and basic procedures of meeting and agenda setting have been formalized. Further formalization of roles is absent in the four hospitals. On the other hand, discretion of members of both boards preponderantly is limited by norms of mutual informing and joint decision making that have not been written down but are strongly felt, for instance, the case of a member of the Board of Medical Specialists of hospital 3 who comments on the Executive Board having gone back from a decision that has been made in consensus with the Board of Medical Specialists about the distribution of slots in the operation theater. Revoking a decision that has been made in consensus with medical staff triggers the question of trust:

The Board of Medical Specialists met with facts it did not know. But we decide together, pull together and then there is a decision that is at odds with this. Trust takes a long time but vanishes quickly. Well, at this point it vanishes immediately.

4.2.2 | Behavioral norms and trust

While specification of tasks and responsibilities is nearly absent, behavioral norms about sharing power and activities are strongly held. Members of both boards recognize the fragile situation in which they operate. As their positions are only superficially formalized by rules and regulations, the interaction between them is very sensitive to, even small, disturbances.

For example, informing each other on even minor issues is seen to be crucial, as an indignant member of the Board of Medical Specialists (hospital 3) comments on the visit of UK doctors to the hospital, which was not informed timely to his or her board:

I heard this only last Tuesday. At that time, everything has been planned already, there was a program, one of the doctors was asked to deliver a speech. But the Board of Medical Specialists did not know, well, you cannot do that, they have to know.

Because of the frailty of interaction, respondents mention trust as a crucial characteristic of their relation. The relevance of trust is mirrored in respondents' remarks about distrust that always lies in wait. The office manager of the Board of Medical Specialists (hospital 2) describes:

I think communication of all members falls short. And they keep things for themselves that they better could have told. That is why distrust comes into existence (...).

Low formalization by rules and regulations invokes the relevance of behavioral norms and trusting relations. At this backdrop, respondents often refer to the relevance of personal competencies and characteristics. For effective communication, personal characteristics play an important role in the collaboration of the boards. Respondents refer to the relevance of the "matching" of the persons in both boards. A doctor of hospital 4 comments on the newly appointed member of the Executive Board and his or her competences compared with those of his or her fellow member of the board:

He (the fellow-member) is glad to have a colleague who is complementary to the Board's practice. I think he is to the medical staff's liking. (...) And I notice that he pushes the right buttons of a doctor by making a certain remark.

Summing up, decision-making arrangements at hospital level rest on boundary-spanning positions, low formalization, and, subsequently, the important role that agreed behavioral norms and trust play.

4.3 | Structuring at unit level

At unit level, the translation of the organizing principles shows an identical pattern. The four hospitals are structured by two advanced positions that are commissioned to execute shared responsibility. As the consequence of dual governance, the MM and his or her counterpart at unit level, the HM (in Dutch, "Bedrijfskundig Manager"), are "running" the unit together. Both positions can be described as boundary-spanning positions on behalf of their "silos," being the representatives of not only their organization—hospital or medical staff—but also each other's partner in the joint decision making of the unit (see Figure 1).

The MM is appointed by the colleagues of the partnership or department as their representative in management at unit level for a certain period. MMs enact two roles: He or she is the representative of the colleagues in the specialty and the partner of the HM in their joint decision making. The MM is executing the job at a part-time basis,

usually 1 or 2 days a week, depending on the size of the unit. In some cases, the MM's responsibility embraces more than one medical specialty. Hospitals pay MMs for this part of their work. The HM who is a full-time job has two roles also. He or she is the representative of the hospital governance chain and at the same time the partner of the MM in joint decision making.

Hospital documents and respondents consistently stress partnership in terms of shared responsibility of both positions. A document of hospital 2 underlines the common responsibility of both positions clearly:

The MM and the HM are the figurehead of the Unit. There are no descriptions of job requirements. However, there have been descriptions of required competences in which the dual character can be recognized: common problem-solving, (...) organization sensitivity, recognition of one's own influence and consequences of decisions or activities and recognition of interests.

Respondents endorse this picture of togetherness and mutual trust. An MM of hospital 3 says:

They (MM and HM) work as a duo, in unity, hand-in-hand.

A member of the Executive Board (of hospital 4) even uses a family metaphor to express shared responsibility and mutual trust at unit level:

They really are the father and mother of the unit and we always held them accountable in togetherness. If we in our role of Executive Board should address them individually, this will not work.

The positions of MM and HM are strewn with problems in one or both of their roles that can only be solved by personal competences. The problems of the MM and HM in living up to the expectations of their two conflicting roles are highlighted in many comments by the respondents underlining the importance of strong persons in these positions. MMs report problems especially with their mandate depending on the attitude of the rank and file. In fact, there are large differences between them concerning their authority. Some of the MMs are given the authority to jointly manage the relevant things together with the HM. But there are also MMs who have a very limited authority to do so, to the effect that the MM is only a "go-between" and all doctors interfere in decision making. One of the HMs of hospital 3 estimates that in his or her hospital half of the MMs is only the "jack of all trades" who has been assigned to the job. Behind the appointment of an MM, many possible motives can play a part, varying from the MM "who's turn it is" to an "unexpected mid-career opportunity." As a member of the Executive Board of hospital 1 states:

For some it is a fatigue-party.

Authority of the MM as a representative is relevant not only to the rank and file but also to the HM as a partner in decision making at unit level. The MM who has not been given authority to jointly manage things causes problems in decision making, as an HM of hospital 1 states:

It's much easier to decide with the person who has authority because one knows things will be executed the way they have agreed (...). If I do so with the MM who has no authority then I know I have to discuss things again in the whole group. (...). So, concerning each policy question I need to know very well how I'm going to tackle, shall I send an e-mail, shall I arrange a meeting, with whom? Indeed, one has to know how relationships are.

In the interviews, especially the MM's partner, the HM is depicted as the incumbent of a puzzling position being a member of the hospital's hierarchy and at the same time very much dependent on the MM's behavior.

4.3.1 | Formalization of positions and relations

Formalization by job descriptions and rules again is low. Official documents describe the roles of MM and HM only in terms of shared responsibility for about all subjects relevant to the unit. There are no specifications of the tasks and

roles nor job descriptions that define tasks and roles in some detail. For instance, the task of the HM in hospital 2 has been described only in generalized manner:

The HM's task is to determine and to safeguard together with the MM hospital policy on quality, continuity and efficiency of patient care and to contribute to the coordination of the total of care delivery in the Unit so that patient-oriented, venerable, safe and efficient care will be produced.

And regarding the crucial subject of financial control, the document states:

Together with the MM sees to and possibly improve the business processes in the Unit so that agreed financial and production results will be reached.

In their opinion, respondents experience too little support by lacking formalization by rules and regulations. HMs report lots of complaints about the ambiguous situation in which they do their jobs and some, as an HM in hospital 1, see their ambiguous position as an "error" in hospital structure. Some of them express their feelings about their position, seeing themselves as "victims" experiencing too little protection by rules and regulations. An HM in hospital 3 comments:

The HM's are expected to do the unpopular work for the Executive Board.

His or her colleague in the same hospital expresses the same feeling in speaking of "unpleasant jobs" while another colleague refers to the danger to become the laughingstock of the hospital.

An HM in the same hospital asks whether he or she is only the "extension of the Executive Board" whereas an HM in hospital 2 comments:

Sometimes it seems that we are a kind of "puppet on a string" of the Executive Board.

However, HMs not only experience problems with their governance chain. The equivalence of HM and MM, loudly praised in interviews as well as in documents, is much commented upon. An HM of hospital 1 says:

Eh, consensus means that we agree as much as possible. But if doctors ultimately say "this is not what we will do" then the HM is at the downside. This is part of our model. If we do not succeed in reaching consensus the doctor is in the lead concerning the production targets (...).

An HM of hospital 3 stresses the frailness of his or her position:

Because the HM, he will have to foot the bill. The HM's are crucial for the management of the unit, they are in permanent and close contact with the Controllers and with the management slush as to "these are the purposes, these are the requirements, this is your target", this is the modern management vocabulary. But the HM has to translate them, meeting a totally different world of the heads of departments which is nearly impossible. So, the HM catches it.

4.3.2 | Behavioral norms and trust

Against the backdrop of units lacking job descriptions and rules, MMs and HMs frequently express the relevance of behavioral norms to practice shared responsibility. These norms are deeply felt but not written down. An MM of hospital 4 stresses the relevance of consensus and trust as dominant norms that guide their relation:

A MM ... is the primus inter pares. There is no hierarchical relation. So, the MM needs sufficient legitimacy and trust by the group. At the same time, the MM has to be accountable to the things that have to be done because of hospital policy. He has to do his utmost. All decision-making is done in consensus. I try to keep everyone informed about the process, this takes lots of time that isn't there. This is difficult. They trust me better as long as they see I do the right things, this is what I reap by organizing things for the unit, this helps

As specifications of their tasks and rules are lacking, MMs and HMs are more or less groping for their way. Criteria for successful working of dual governance at micro-level are only found in terms of personal competencies, not managerial qualifications. An MM of hospital 4 comments:

(...) So, it's a matter of searching. To maneuver within the agreements. It is difficult to work without clear job description. (...) The way to work is up to myself. I have been appointed by the Executive Board. That's all there is. And then, we have our monthly talks and coordinate things with the HM permanently. It's only common sense.

And a document of hospital 2 defines shared responsibility of the MM and HM even in terms of creating "golden couples" to do the job. Relationships can be improved by finding the "match" of MM and HM as a person. Interestingly, the document stresses the importance of HRM finding the right "match" in "golden couples."

Summing up, decision-making arrangements at hospital level and unit level, which have been structured by consciously designed ambiguous positions, embrace two conflicting roles of representative and partner. Just like at hospital level, formalization by job descriptions and rules at unit level is low and shared responsibility is key. Behavioral norms on mutual understanding and trust are felt crucial for success but have not been written down. Personal competencies and characteristics are very relevant for their interaction because the two roles come into conflict easily. Personal strength is assumed—especially relevant for the HM—as behind the façade of mutuality and shared responsibility doctor's dominance lurks.

5 | CONCLUSION

In this article, we have sought out to analyze management-medical specialist relations in hospital governance, looking specifically at the ways in which relations between the actors have been structured in decision-making arrangements. To this end, we have performed extended qualitative research in four Dutch hospitals. The research shows a pattern of similar paradigms and measures taken by the four hospitals to improve their governability. The designs of the hospital structures we researched share the following four building blocks of the dualistic hospital governance model, resting on the structuring of ambiguous positions.

First, hospital management and medical specialists embrace duality as a fact of (hospital) life followed by the contention to organize mutual dependence at hospital level and unit level. This fundamental choice can be analyzed as "pragmatic collaboration"³⁸ in which the actors search for workable and viable relationships, at odds with the monolithic hospital structure's positioning of general management prescribed by governmental regulation.

Second, hospital management and doctors organize duality by structuring relevant positions in the decision-making system of the hospital. These positions can be identified as boundary-spanning positions granting the incumbents much discretion to fulfill their two conflicting roles of representative and partner.³⁷ At hospital level, the Executive Board and the Board of Medical Specialists agree to "upgrade" the Board of Medical Specialists, to their shared responsibility and to share activities as much as possible; in short, they agree to cogovernance. At unit level, the positions of MM and (nonmedical) HM have been created to do the same. The positions contain the roles of representative and partner, but partnership is expected to dominate the role-playing by the incumbents.

Third, actors choose to keep formalization by rules and job descriptions low. Official documents describe only the tasks and responsibilities in a generalized way. Instead, unwritten but strongly felt norms of mutual understanding control behavior.²⁹ In many interviews, respondents express the relevance of behavioral norms and trust in controlling behavior. As specifications and rules are lacking, trust—defined as the mechanism that mediates interaction in situations of unpredictable role behavior—is indispensable for decision-making quality. In this sense, trust is a functional equivalent for the exercise of power in role conflict when systematically defined roles are absent and actors have to negotiate their mutual binding norms.³⁹

Fourth, ambiguous positions ask for strong people. The positioning of doctors and managers at both levels implies the introduction of role conflict combining the role of partner with the role of representative of a party of doctors. The role of representative is especially difficult because of the important process of generating commitment within the rank and file.⁴⁰ To accomplish role conflict, motivated and capable people are needed. Personal competencies and characteristics are very relevant in this hospital governance system. However, dependence on personal competencies and characteristics causes vulnerability of the decision-making arrangements as institutions.

5.1 | Consequences for governability

The research offers some insights into the consequences of structuring the hospital with ambiguous positions. We distinguish four consequences for governability of the hospital. First, ambiguity may be a solution rather than a problem. To value the possible positive contribution to governability, we have to say something about the concept of ambiguity. Generally, it stands for contagious, arbitrary, unforeseeable, and contradictory—in short uncontrollable—behavior of organizational members. The concept carries a bad reputation as it is seen from the monolithic or bureaucratic perspective and its principle of unambiguity.⁴¹ However, an alternative perspective on ambiguity may rebalance the concept's meaning. If we acknowledge the hospital from another perspective in which boundary-spanning roles provide for the necessary coordination of more or less autonomous entities, we may reconsider this picture. Indeed, boundary-spanning roles always carry much uncertainty and unpredictability with them because there is no alternative way to do the job.³⁷ Ambiguity in roles does not have to be a problem; it can even be a solution to coordination problems. Ambiguity may open up new routes in improving governability of hospitals by granting members more instead of less discretion⁴¹ by that creating more capacity to govern.

Second, our data suggest that this model's strength lies in the improved legitimacy of the decision-making processes, which can prevent—or better handle—conflict between hospital management and doctors. Decision-making arrangements comprise the promise of strengthening governability as hospital management and doctors practice decision making at an equal footing. Meeting the political challenge of doctor-management relationship in this way is a very relevant part of improving governance arrangements.⁴²

Third, ambiguousness produces not only chances to improve governability but also new challenges. Working with ambiguous positions may be advantageous for coordination; it also may cause disadvantageousness to effective and efficient decision making. The combination of the roles of partner and representative may especially cause complex and slow decision-making processes as proposals travel back and forth between the partner and the rank and file.⁴³ Also, there is legitimate fear that consensus management leads to worsened quality of decisions because of possible nondecision and lowest common denominator decisions.

Fourth, the hospital's dependence on ambiguous positions underlines the relevance of personal competencies and characteristics for hospital governance, which can be seen as its strength as well as its weakness. Indeed, hospital coordination is dependent on personal competences and characteristics, which makes “matching” the “right” persons very relevant and in turn enlarges the relevance of organizational support. For instance, recruitment, training, and coaching of “lone wolfs” are crucial for accomplishment of these complex and difficult jobs.²⁵ Supporting departments like HRM will have to take account into this, making the department, as a part of hospital technostructure, more relevant for hospital governance. Strengthening technostructure is consequential for the power balance of professional organizations.²⁸

6 | DISCUSSION

In redesigning their decision-making arrangements, like the four hospitals in our research, many Dutch hospitals choose a similar perspective to improve their governability. They seek to redesign hospital decision-making arrangements while restoring more or less the “old” model of dual hospital governance coupled with mutual consultation,

negotiation, and consensus decision making, resting on ambiguous positions that make the model work. At the same time, in redesigning their decision-making arrangements, hospitals have to comply with the prevailing laws on hospital governance prescribing the monolithic model and the final responsibility of general management. How do the hospitals in our research deal with these competing governance models and their different logics?

Studying our data, hospitals cope with the situation by decoupling.⁴⁴ They disconnect the prescribed, monolithic model from the desired, dualistic model in the way Goffman distinguishes front-stage and backstage worlds.⁴⁵ The prescribed model serves as the formal, front-stage world and the dualistic model as the backstage world in which management and doctors experience their mutual dependency to produce high-quality healthcare. Adhering to this model, they choose pragmatic collaboration to create workable and viable relationships in their hospitals.³⁸ The practice of decoupling demonstrates the far-reaching autonomy of hospitals in Dutch governance system.

6.1 | The results in comparative perspective

The research may produce three additional insights if we view the results in an international perspective. First, governance strategy of Dutch hospitals seems unique as they seek the involvement of doctors in hospital governance *not* by appointing doctors into managerial positions and roles—as in many European countries—but by employing representatives of doctors who—together with their counterparts—practice boundary-spanning roles. In other words, they do not integrate clinicians into hospital management, which may exert a preserving effect on their “silos” and adjacent cultures. Dutch medical management typically takes shape by representation, consultation, and negotiation.

Second, choices the hospitals in our research make regarding their decision-making arrangements underline their far-reaching autonomy in Dutch governance system. They even decouple from the governmental governance model and go their own way. In Dutch governance system, this is not a very startling fact. Autonomy of hospitals—as well as other healthcare organizations—is historically high. In the Netherlands’ “consensualist” culture, hospital governance reflects permanent consultation and negotiation between actors at all levels of the governance system, as can be illustrated by the divergent introduction and development of performance-indicator regimes in the Netherlands and, for instance, England. In the Netherlands, NPM measures are much less edgy than in England, as English governance system traditionally grants far less autonomy to hospitals. It has been typified by Western European standards as “unusually centralized” government is normally able to impose itself on local authorities.⁴⁶ However, future hospital governance may look quite differently. As in other countries, in post-NPM England, the “process of autonomization” is developing fast as foundation trusts are granted much more discretion.¹ This trend fits in with a more general trend in Europe in which hierarchical governance systems retreat in favor of more autonomy of hospitals and therefore more network-oriented systems.^{47,48}

6.2 | Suggestions for further research

The study has some limitations that may be met by future research. First, we assume that many Dutch hospitals practice similar hospital governance structure as “our” hospitals that participated in the research. However, quantitative data are needed to study trends in hospital governance models.

Second, although our research has found some relevant building blocks that may signal a route to improve governability, new challenges arise. One of the challenges concerns the consequences of dual hospital governance for efficiency and effectiveness of decision-making processes in the hospital.

Third, as respondents suggest, cogovernance of medical specialists and its notions, perhaps rhetoric, of shared responsibility and togetherness might distract from the underlying power balance of managers and doctors. Respondents point to these decision-making arrangements opening up chances for doctors to be “in the lead.” Future research may study the consequences of dual hospital governance for the power balance of management and doctors.

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REFERENCES

1. Saltman R, Durán A, Dubois H. *Governing Public Hospitals. Reform Strategies and the Movement towards Institutional Autonomy*. Brussels: WHO; 2011.
2. Glouberman S, Mintzberg H. Managing the care of health and the cure of disease—part I: differentiation. *Health Care Manage Rev*. 2001;26(1):56-69.
3. Pool J. Hospital management: integrating the dual hierarchy? *Int J Health Plann Manage*. 1991;6(3):193-207.
4. Johnson G, Whittington R, Scholes K. *Exploring Strategy*. Harlow: Pearson; 2011.
5. Reay T, Hinings CR. Managing the rivalry of competing institutional logics. *Org Stud*. 2009;30(6):629-652.
6. Scholten GRM, van der Grinten TED. Between physician and manager: new cooperation models in Dutch hospitals. *J Manag Med*. 1998;12(1):33-43.
7. Freidson E. *Professionalism: The Third Logic*. Cambridge: Polity Press; 2001.
8. Peters B, Pierre J. Developments in intergovernmental relations: towards multi-level governance. *Policy Polit*. 2001;29(2):131-135.
9. Freiberg A. *Regulation in Australia*. Leichardt: The Federation Press; 2017.
10. Wallenburg I, Quartz J, Bal R. Making hospitals governable. Performativity and institutional work in ranking practices. *Adm Soc*. 2016;1-27.
11. Kooiman J. Exploring the concept of governability. *J Comp Policy Anal Res*. 2008;10(2):171-191.
12. Maarse J, Moen J. Instrumenten van beleid: De doorwerking vanuit een organisatie-theoretisch perspectief. *Beleidswetenschappen*. 1991;2:132-147.
13. Pollitt C, Harrison S, Hunter J. General management in the NHS: the initial impact 1983-88. *Public Adm*. 1991;69, Spring:61-83.
14. Tap H, Schut F. Escaping from the dual organization: physician self-governance. *Int J Health Plann Manage*. 1987;2(3):229-242.
15. Kuhlmann E, von Knorring M. Management and medicine: why we need a new approach to the relationship. *J Health Serv Res Policy*. 2014;19(3):189-191.
16. Hood C. A public management for all seasons. *Public Adm*. 1991;69(1):3-19.
17. Rotar A, Botje D, Klazinga N, et al. The involvement of medical doctors in hospital governance and implications for quality management: a quick scan in 19 and an in depth study in 7 OECD countries. *BMC Health Serv Res*. 2016;16(Suppl 2):160.
18. Selznick P. *TVA and the Grass Roots. A Study in the Sociology of Formal Organization*. New York: Harper and Row; 1966.
19. McGivern G, Currie G, Ferlie E, Fitzgerald L, Waring J. Hybrid manager-professions identity work: the maintenance and hybridization of medical professionalism in managerial contexts. *Public Adm*. 2015;93(2):412-432.
20. Fitzgerald L, Ferlie E. Professionals: back to the future? *Hum Relat*. 2000;53(5):713-739.

21. Veronesi G, Kirkpatrick I, Altanlar A. Clinical leadership and the changing governance of public hospitals: implications for patient experience. *Public Adm.* 2015;93(4):1031-1048.
22. Jones L, Pomeroy L, Robert G, Burnett S, Anderson J, Fulop N. How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England. *BMJ Qual Saf.* 2017;26(12):978-986.
23. Kirkpatrick I, Kragh Jespersen P, Dent M, Neogy I. Medicine and management in a comparative perspective: the case of Denmark and England. *Social Health Illn.* 2009;31(5):642-658.
24. Scholten G, van der Grinten T. Integrating medical specialists and hospitals. The growing relevance of collective organization of medical specialists for Dutch hospital governance. *Health Policy.* 2002;62(2):131-139.
25. Kuhlmann E, Rangnitt Y, von Knorring M. Medicine and management: looking inside the box of changing hospital governance. *BMC Health Serv Res.* 2016;16(Suppl 1):57-64.
26. Dawson S. *Analysing Organisations.* London: Macmillan Press; 1996.
27. Lowndes V, Sullivan H. How low can you go? Rationales and challenges for neighborhood governance. *Public Adm.* 2008;86(1):53-74.
28. Mintzberg H. *Structure in Fives: Designing Effective Organizations.* Englewood Cliffs: Prentice Hall; 1983.
29. Hall R. *Organizations. Structures, Processes, and Outcomes.* Englewood Cliffs: Prentice-Hall; 1987.
30. Muijsers-Creemers L. Samengesteld Besturen: De kracht en kwetsbaarheid van duale besturing in algemene ziekenhuizen. PhD-Thesis Rotterdam: iBMG/Erasmus Universiteit 2016.
31. Yin R. *Case Study Research: Design and Methods.* Thousand Oaks, M.A.: Sage; 2014.
32. Balogun J, Huff A, Johnson P. Three responses to the methodological challenges of studying strategizing. *J Manag Stud.* 2003;40(1):197-224.
33. Geertz C. *The Interpretation of Cultures.* New York: Basic Books; 1973.
34. Scholten G, van der Grinten T. The integration of medical specialists in hospitals. Dutch hospitals and medical specialists on the road to joint regulation. *Health Policy.* 2005;72:175-173.
35. Saltman R, Duran A. Governance, government, and the search for new provider models. *Int J Health Policy Manag.* 2016;5(1):33-42.
36. Koppenjan J, Klijn E. *Managing Uncertainties in Networks: A Network Approach to Problem Solving and Decision Making.* London: Routledge; 2004.
37. Aldrich H, Herker D. Boundary spanning roles and organization structure. *Acad Manag Rev.* 1977;2(2):117-230.
38. Sabel C. Pragmatic collaborations in practice: a response to Herrigel and Whitford and Zeitlin. *Ind Innov.* 2004;11(1-2):81-87.
39. Seligman A. *The Problem of Trust.* Princeton: Princeton University Press; 1997.
40. Greenhalgh L, Lewicki R. Evolution of teaching negotiation: the legacy of Walton and McKersie. *Negot J.* 2015;31(4):465-476.
41. Levine D. *The Flight from Ambiguity: Essays in Social and Cultural Theory.* Chicago: Chicago University Press; 1985.
42. Bate P, Mendel P, Robert G. *Organizing for Quality: The Improvement Journeys of Leading Hospitals in Europe and the United States.* Oxford: Radcliffe Publishing; 2008.
43. Provan K, Kenis P. Modes of network governance: structure, management and effectiveness. *J Public Adm Res Theory.* 2008;18(2):229-252.
44. Bromley P, Powell W. From smoke and mirrors to walking the talk: decoupling in the contemporary world. *Acad Manag Ann.* 2012;6(1):1-48.
45. Goffman E. *The Presentation of Self in Everyday Life.* New York: Anchor Books; 1990.
46. Pollitt C, Harrison S, Downswell G, Jerak-Zuiderent S, Bal R. Performance regimes in health care: institutions, critical junctures and the logic of escalation in England and the Netherlands. *Evaluation.* 2010;16(1):13-29.
47. van Ineveld M, van Wijngaarden J, Scholten G. Choosing cooperation over competition; hospital strategies in response to selective contracting. *Int J Health Plann Manage.* 2018;1-11. <https://doi.org/10.1002/hpm.2583>
48. Rhodes R. Understanding governance: ten years on. *Org Stud.* 2007;28(8):1243-1264.

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