PREFACE

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Dr Hédi Guelmami's book, *Hospital Management, the Manager's Guide,* is exemplary in several respects. It deals with an important and little-studied subject, that of the management of clinics, and this importance is growing both because of the ageing of the population and because of the limits encountered by the public hospital sector. It deals with a very topical subject in many countries where the clinic sector is undergoing both regulatory changes and increased investment needs in terms of equipment. It addresses the issue of the performance of private clinics in relation to their internal management, which is a contribution that will be of interest to all clinic directors and managers. The use of a combination of qualitative and quantitative data facilitates the generalisation of results and managerial recommendations. At the same time, it does not erase the finesse necessary in any science that involves humans.

The book is also exemplary for the dual conceptual and managerial perspective that its author brings. This incisive and relevant look at the relationship between the clinic and the organisation is made possible by the author's dual training as a Doctor of Medicine and a Doctor of Business Administration, the latter having been prepared at Business Science Institute in parallel with his activity as CEO of a clinic, his thesis defended in front of an international jury at the Château de Wiltz in Luxembourg in October 2015.

INTRODUCTION

"Whoever undertakes to set himself up as a judge of Truth and Knowledge is shipwrecked by the laughter of the gods."

Albert Einstein

The private profit-making health sector plays a key role throughout the world, given its capacity to participate in the provision of care. This sector is thus occupying an increasingly important place in the world of health care. The clinic is put forward as a solution to the various problems inherent within public health systems, which raises many controversies about its governance.

1. THE CLINIC: AN ACTOR IN ITS OWN RIGHT

The clinic is an extension of the individual medical practice with a mini technical platform allowing doctors to practise their art and perform their procedures. The practitioner, usually a surgeon or gynaecologist, works alone in this "clinic-villa" model. With progress in the medical sector, and the cost of modernizing technical equipment, individual doctors are grouping together to cope with these financial constraints. The transition from individual to collective practice led to the creation of the private clinic as a structure and organisation referred to as the "eponymous clinic" (Piovesan, Pascal and Claveranne, 2007).

Gradually, these clinics are being bought up by financial structures, thus evolving towards the format of anonymous clinics or group clinics owned by non-medical investors. The modes

of governance differ according to the type of clinic (Piovesan, Pascal and Claveranne, 2007).

In sociology and economics, work in the field of health care has only focused on the public sector (Tschenling, 2000 reported by Claveranne, 2003); as a result, the private clinic has remained "an unidentified management object" (Claveranne, 2003, p. 143).

Through its services, as well as its economic weight, the private clinic is an actor in its own right in the health system. In Tunisia, health care expenditure rose from 3.2% of GDP in 1980 to 5.6% of GDP in 2008, with the share of households at 40.28%. The private sector, composed of 86 clinics, consumes 48% of total expenditure, financed by private funds (direct household expenditure, insurance) and a smaller part by the National Health Insurance Fund (CNAM). Households are the main financers of the private sector since they allocate 85% of their health expenditure to it (Achour, 2011). However, the private sector has continued to evolve despite geopolitical conditions over the past three years. The private sector currently has almost 4,500 beds, which represents 18.65% of the total number of hospital beds.

2. THE CLINIC: A COMPLEX ORGANISATIONAL MODEL

The private clinic has given rise to organisational transformations and innovations in which the collective forms of action are constantly evolving due to a central actor, namely the doctor (Claveranne, Pascal and Piovesan, 2003), known as the "professional" (Mintzberg, 1998) or the "key figure" (Michel, 1999).

The practice of medicine can no longer indeed be limited to the relationship between the doctor and their patient, without taking into account the technical equipment, the resources and the expertise, which leads to the need for in-depth reflection on the managerial style of this collective organisation.

The clinic space represents a real area of activity in which the practices of the various participants or actors are coordinated, each with their own conception, logic, priorities and interests.

Contandriopoulos (2008), considers that the regulation of the health system is not subject to a single design, given the diversity of the groups of actors interacting within it.

The private clinic is therefore a place where several actors (investors, doctors, patients, etc.) come together, generating relationships built around a technical platform. The clinic as an organisation that functions as a "nexus of contracts" between the different actors, according to the theory (Jensen, 1983), or as a "nexus of treaties" (Aoki, 1990 agency).

Jensen and Mickiling (1976), see organisations as legal fictions providing a set of contractual relationships between individuals as the core.

The private clinic has an organisational complexity involving several companies composed of several actors with different interests. These include an operating company, a real estate company and one or more civil companies composed mainly of doctors across various specialties. This complexity depends on the organisational architecture of the Clinic network (Figure 1).

The manager must then translate into a language understood by all, what the different actors want, why they behave in certain ways, and how they interact with the other actors. The negotiation, alliance, conflict of interest and tensions underlying the roles must be clear to the manager, so that they can succeed in the translation process.

Claveranne (2003) considers that the private clinic functions as a network: "As soon as medical knowledge was shared between professionals, adjustments between them were made around and from networks that were formed according to skills and knowledge, but also schools of thoughts, tendencies and even financial interests" (Claveranne and Pascal, 2001, p. 148).

3. STAKES

The organisational architecture of the private clinic is dynamic, in perpetual movement, with a diversity of actors acting sporadically and in an unsynchronised manner. The regulation of this

organisation is carried out by the clinic's manager, who is responsible for harmonising the voices of all the actors.

The manager must know how to translate into a language understood by all, what the different actors want, why they act as they do, and how they relate to each other. The games of negotiation, alliances, conflicts of interest and the inherent tensions must be understood by the manager so that they can successfully carry out the task of translation.

Through this process of translation, the network is formed in a pro-active way, engaging all stakeholders in order to achieve alignment.

We consider that the network of a private health care structure is made up of a set of diverse actors coordinated by a manager, participating in the elaboration and dissemination of medical innovations and managing the relationships between the caregiver, the care recipient and the institution, through the alignment of numerous interactions.

This leads us to questions about the management of a health care structure in general, and a private one in particular, and its tools for improvement.

This problem is broken down into other research areas, in particular how to satisfy the main actors working in the health system, as well as the measurement tools to be developed to evaluate the level of satisfaction of each actor.

The profile of the manager in charge of a health care structure leads us to reflect on their profile and the notion of hybridisation.

This book is thus situated in the field of management, touching on strategy, organisational formats, as well as the management of human resources, in particular the main actors working in the private health sector... a sector thus far little explored in the management sciences.

4. STRUCTURE OF THE BOOK

To address these points, the book is divided into five chapters:

Chapter 1: focuses on a review of the literature on the private clinic as a profit-making enterprise in the health sector. A historical approach describes the transition from the "clinic-villa" model to the "eponymous clinic", sealing the transition from an individual to a collective mode of practice, with a historical actor: namely, the doctor (Piovesan, 2007).

The private clinic has evolved anonymously, following the takeover of its structures by non-professional financial groups (non-medical). Today, it is a fully-fledged actor in the health sector, little explored, dynamic and which has undergone transformations and organisational changes. It is a space where the various actors interact with each other, where interests clash and where the manager tries to manage and coordinate the range of activities.

From Agency Theory to the notion of stakeholders, *via* clinical governance, the organisational architecture of a private clinic appears to be the result of the sedimentation of different organisational forms (Mintzberg, 1998, in Claveranne, 2003, p. 144).

Chapter 2: illustrates the conceptual framework through an in-depth description of Michel Callon's Theory of Translation, which he developed based on the work of Michel Serres in the mid-seventies.

Through the scientific and economic controversy on the domestication of Saint-Jacques scallops in Saint-Brieuc Bay (Callon, 1986), we use the notion of translation to identify the actors or actants (human and non-human actors), intervening around a private clinic, thus constituting a network.

We use this theory to describe the dynamics of the emergence of an alignment in the management of a private clinic.

Chapter 3: illustrates the results of a first qualitative study through interviews with ten managers of private clinics in Tunisia.

We adopt a mixed research methodology, consisting of a qualitative empirical study and a quantitative study (Bosisio, 2014).

Our paradigmatic positioning stems from an ontological position and an epistemological position. The ontological approach is derived from the Theory of Translation where reality is emergent and depends on the context in which it is observed, as well as the conceptual schemes and theoretical frameworks in which the researcher works, hence the relativistic approach. The epistemological position adopted is that of the theory of translation, which refuses pure positivism while relativising the constructivist positioning (Latour, 1991; Callon, 1999; Renaud, 2012).

We do not oppose the real and the constructed, but we adhere to the fact that reality can only emerge from the field. Furthermore, we share Charmaz's constructivist framework, and consider that the researcher must be involved in the field, without falling into absolute subjectivism (Heath and Cowley, 2004).

The qualitative study is carried out through an inductive approach, aimed at answering our research problem and the research questions that emerge from it. It is based on semi-structured interviews with managers of ten clinics in Tunisia. The qualitative study enabled us to identify all the stakeholders in a private clinic, and to study the interferences between the main actors, which could contribute to improving the management of such a structure.

Chapter 4: illustrates the results of the second quantitative study conducted with the two main actors, namely doctors and patients.

One hundred doctors and one hundred patients participated in this quantitative study. The study made it possible to develop a tool to measure the satisfaction of carers and patients, and to finalise the 3-pole model which led to the alignment of the three main actors studied.

Chapter 5: allows us to finalise the organisational model of a private clinic, based on the results of two qualitative and quantitative studies, carried out with the three main actors of a clinic: the manager by way of the institution, the doctor and the patient.

A 3-pole model is identified: the institutional pole, the health care pole and the patient pole. The links between these three poles demonstrate the expectations of each of the actors towards each other. The clinic manager, whose place is central, uses their status and function to bring out the possible situations of alignment between the three parties involved.

Based on this network and its poles, we use Michel Callon's Theory of Translation, through its four "moments" (problematization, interessement, enrolment and mobilisation of allies), to help the manager to translate and to align. Translation is a dynamic process of constant negotiation and adaptation between actors with different interests. Our results suggest that the success of this translation depends significantly on the profile of the manager/translator.

Chapter 6: is the result of a thorough conceptual reflection carried out in the health sector in general, and the for-profit sector in particular. The aim is to produce innovative ideas and working tools within an analytical and research framework. The outcome of this work will be materialised by a new informed view, expressed through managerial recommendations.

Finally, **the conclusion** summarises our research and shows its originality, our theoretical and practical contributions, limitations as well as avenues for future research.