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Laurent Mériade, Corinne Rochette

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Governance tensions in the healthcare sector: a contrasting case study in France

Laurent Mériade^{1*}

¹IAE Clermont Auvergne - ClerMa
Research Chair "Santé et Territoires"
University Clermont Auvergne
11 Boulevard Charles de Gaulle
63 000 Clermont-Ferrand - France
laurent.meriade@uca.fr
Phone : +334 73 17 77 30

Corinne Rochette²

²IAE Clermont Auvergne - ClerMa
Research Chair "Santé et Territoires"
University Clermont Auvergne
11 Boulevard Charles de Gaulle
63 000 Clermont- Ferrand - France
corinne.rochette@uca.fr
Phone : +334 73 17 77 32

Abstract

Background: Political and managerial reforms affect the health sector by translating into governance tensions. As identified in the public management literature, these tensions come from the diffusion of management principles and practices from the business world. These tensions manifest at four levels: institutional, organisational, managerial and instrumental. The aim of this research is to understand how these tensions are expressed in healthcare organisations of different status.

Methods: We conduct a contrasting case study exploring the cases of two French healthcare organisations, one private for-profit (clinic) and one public not-for-profit (cancer treatment centre). Our analyses are mainly based on the content analysis of 32 semi-structured interviews conducted with staff (nurses, doctors, management and administrative staff) of these two organisations.

Results: Our results show that these tensions can be distinguished into three categories (tensions on professional values, standards and practices) which are expressed differently depending on the type of healthcare organisation and its main management characteristics.

Conclusions: Unexpectedly, in the for-profit organisation, the most intense tensions concern professional standards, whereas they concern professional practices in the not-for-profit organisation. These analyses can help guide policy makers and healthcare managers to better integrate these tensions into their political and managerial decisions.

Keywords: Governance tensions; healthcare organisation; contrasting study.

22 **Introduction**

23 In OECD countries since the early 1970s, political, administrative and economic reform
24 programmes have been underway and some of them are leading to major changes in
25 implementation of public policies. They are generating particularly acute tensions among the
26 employees and managers of the public services concerned [1, 2].

27 These tensions result from the coexistence of opposing demands, or dualities, such as flexibility
28 and control, differentiation and integration, stability and change [3]. Seen in isolation, each element
29 in tension makes perfect sense, but when both elements appear at the same time, their coexistence
30 may seem illogical. However, the two elements are indivisibly interconnected and interdependent
31 [3].

32 As current events show, medical and nursing staff working in French health organisations are
33 particularly affected by these tensions [4]. The number of demonstrations, the nature of the
34 demands expressed, the motivations and the violence observed over the last few years reveal the
35 seriousness of these tensions, which have increased over the last few years in French and European
36 public and private healthcare organisations [4]. These tensions have become even more evident in
37 recent months with the global health crisis caused by Covid-19 [5].

38 The main changes that occurred, enacted in regulations and laws, concern the policy, organisation
39 and functioning of healthcare organisations in France [6]. The increase in the number of patients
40 to care for, the complexity of the cases to be handled due to the ageing of the population, the
41 development of chronic diseases, more and more expensive equipment and an unfavourable
42 medical and nursing demography led to an increase in expenditure, a need to control resources and
43 an overloading of physicians and nursing staff [7].

44 Hospital reforms have often aimed to improve collaboration and coordination between hospitals as
45 well as access, quality and continuity of care [8]. However, these changes have been accompanied
46 by protests and resistance against the various reforms [9-11], particularly in France, over the last
47 20 years [4]. The practices that result from these reforms, which according to health professionals
48 are rooted in values from the market sphere [12], sometimes appear incompatible with the public
49 service mission of healthcare organisations [13]. Nunes et al. [3] in analysing their causes, have
50 shown that these incompatibilities are expressed in the form of dualities requiring meta-capabilities
51 to manage them (Plural consensus, orchestrated emergence, distributed connectedness, patient
52 coreness, formalised fluidity, cautious generativeness). However, beyond an analysis of their causes,
53 these incompatibilities can also be analysed through their consequences on the personnel and
54 production of health services. Indeed, they have ethical, organisational and managerial
55 consequences [14] that we propose to examine through the prism of governance tensions. This
56 analytical framework, widely tested in public management [15], offers the advantage of accurately
57 identifying the effects of public reforms at four levels (institutional, organisational, managerial and
58 instrumental) [16]. The research question we are addressing here is: in the context of political and
59 managerial reforms in health, are governance tensions expressed in healthcare organisations in any
60 way? Can we identify differences in their manifestation according to the status of the organisation?
61 We answer this research question in the following way. First, we revisit the importance of tensions
62 in healthcare organisations between the objectives of public reforms and individual objectives.
63 Second, using the analytical framework of public governance tensions [16, 17], we explore the case
64 of two French organisations, one private for-profit (clinic) and one public non-profit (Cancer
65 Treatment Centre). Finally, our results allow us to identify three categories of tensions (on values,
66 norms and professional practices) expressed with different intensities in the two organisations

67 studied. These results guide decision-makers and managers in the health sector towards taking
68 better account of these tensions in their political and managerial decisions.

69 **Background**

70 **Conceptual framework of the study: Public Governance Tensions (PGTs)**

71 Conceptual approaches that focus on tensions within national organisations and governance
72 systems offer very interesting analytical potential for the management of public organisations [18]
73 [19] and particularly that of healthcare organisations [20]. Tensions arise from incompatibilities or
74 divergences in orientations and actions between, on the one side, a context shaped by challenges,
75 actor dynamics and specific rules [21] and, on the other side, an organisational environment
76 characterised by its constitutional mission, its governance framework, its structures, its objectives,
77 the status of its staff and the evolution of its management mode [22]. Tensions in healthcare
78 organisations show in particular the importance of creating alliances and joint communication
79 between the micro, meso and macro levels of health systems [23]. Indeed, these tensions are
80 expressed externally between the local and central levels of health systems [24]. They are also
81 expressed internally, as close as possible to the health professionals [9]. Thomson, Murtagh, &
82 Khaw [9] have highlighted the importance of tensions between health policy objectives and the
83 missions of health professionals and now encourage further study of these tensions. Since the late
84 1990s, reforms applied to public health organisations have led to significant changes in national
85 systems of public governance [2]. These tensions are expressed in particular between national
86 policy priorities and local views and priorities [25]. They create a 'strategic/local' governance
87 boundary that limits the development of multi-level governance of institutions as the health field
88 would probably require [26]. Exploring the effects of reforms on the governance of public
89 organisations, Hudon and Mazouz [17] show that these tensions affect these organisations at four

90 levels: public values, architecture of organisational structures, formal management frameworks and
91 management instruments [16] [17] (Figure 1). They identify four categories of tensions on the roles,
92 functions and responsibilities of public managers: ethical tensions, organisational tensions,
93 managerial tensions and artefactual tensions (Figure 1).

94 - Ethical tensions arise from the difficulty of making the public service mission possible to coexist
95 with increased public performance as considered by the institutional promoters of NPM [27, 28].
96 It leads to a re-examination of the ethics of staff and public agents [29, 30]. In the health field, these
97 ethical tensions appear in particular in the balance between the individual and collective
98 responsibilities of staff [31].

99 - Organisational tensions can be caused by the reorganisation of work, the reconfiguration of
100 hierarchical relationships, coordination mechanisms or the allocation of resources [32, 33].

101 - Managerial tension is a consequence of the evolution of official administrative frameworks (e.g.
102 activity-based financing) in France [34]. It is perceived at the implementation level of the law and
103 administrative rules that lead to tensions between different public professions [35].

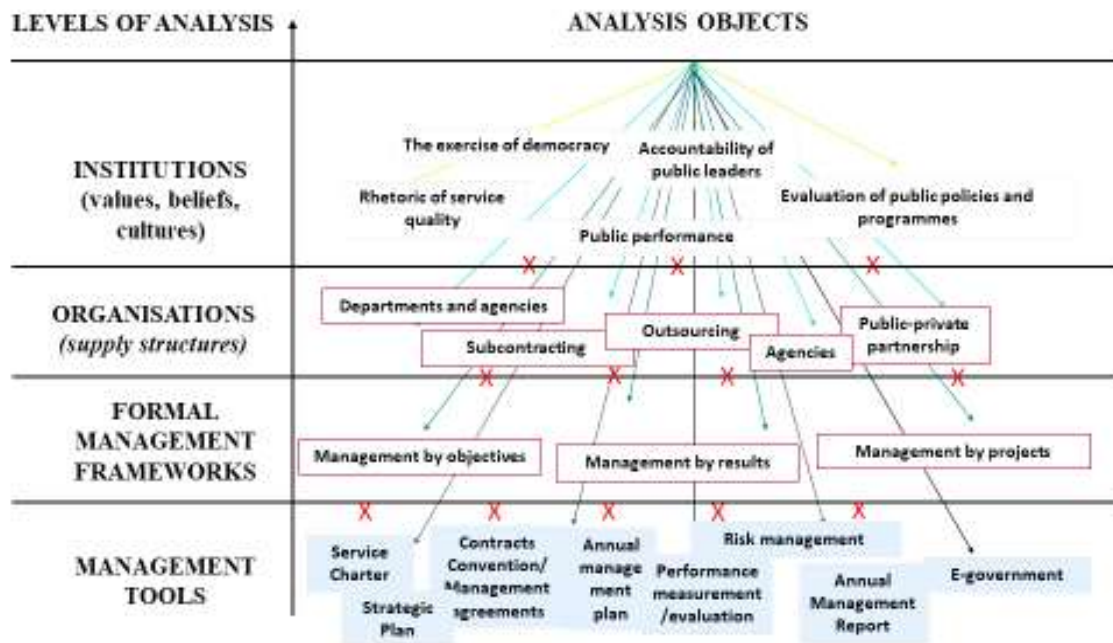
104 - Artefactual tension refers to the instrumental level (or management tools). It arises from the
105 difficulty of matching instruments focused on measuring and evaluating results (the managerial
106 logic) with instruments derived from a bureaucratic logic that focuses on the regulation of rules
107 and means [2,22, 36]. However, these tensions are not insoluble, and the challenge for public
108 governance is to develop approaches that establish 'virtuous circles' of management instruments
109 from different logics (managerial, bureaucratic or medical) [37].

110

111

112

113 **Figure 1. Configuration of a national public governance system (Source: adapted from [16]**
 114 **and [17])**



X: Risk of Public Governance Tension (PGT)

115
 116 The interest of applying this framework of analysis of PGTs in health organisations lies in its
 117 capacity to illustrate tensions by their consequences, which are often more easily perceived and
 118 expressed by health professionals. The application of this framework therefore complements the
 119 work that focuses on the causes of tensions [3], with a view to possibly combining these two
 120 approaches in future work.

121 **Methods**

122 The methodology used is that of a contrasting case study. It is consistent with the replicative
 123 research strategy recommended by Yin [38]. The operational approach consists of using the same
 124 conceptual and theoretical framework to study one case, then another or others. This approach has
 125 the advantage of strengthening the external validity of the knowledge produced in a qualitative
 126 approach [39]. It is particularly suitable for studying organisational change experienced by
 127 healthcare organisations over the last two decades.

128 **Presentation of the French context and the two cases studied**

129 In France, the healthcare sector has been undergoing major reforms for more than 20 years,
130 resulting in the adoption of a results-based approach [40] inspired by the new public management
131 [41]. Many factors explain the emergence of tensions in France: the adoption of activity-based
132 pricing (T2A), a polarisation and concentration of care activity in urban centres, a large increase in
133 the number of patients to be cared for, more and more often with chronic and complex pathologies,
134 a shift and increased tasks towards care staff and a lower valuation of remuneration, which lead to
135 a lack of nursing staff and recruitment difficulties. Numerous protests and demonstrations have led
136 the Ministry of Solidarity and Health to organise a consultation of the healthcare system's actors in
137 2020 in order to simplify the organisation and daily life of healthcare professionals in the public
138 sector and to reduce tensions. Among the measures announced from 2021, there is a reduction in
139 the share of activity-based financing (T2A), the abolition of the Inter-ministerial Committee for
140 the Performance and Modernisation of the Hospital Care System, which will be replaced by a
141 French National Investment Council, a revaluation of public hospital staff and the opening of
142 discussions to the private health sector.

143 In France, there are three types of healthcare organisations:

144 – Public health organisations (1,389 organisations in 2019 [42]). These are legal persons under
145 public law with administrative and financial autonomy. They are subject to State control. Their
146 main vocation is neither industrial nor commercial. These university hospital centres are involved
147 in both medical and pharmaceutical research and medical and paramedical education.

148 – Private not-for-profit establishments (689 organisations in 2019), generally from religious,
149 charitable or mutualist movements. These are private health establishments. They are qualified as
150 being of collective interest as long as they provide a public hospital service.

151 – Private for-profit organisations (1,014 organisations in 2019). These are private clinics with a
 152 health and commercial vocation managed by private funds and management. Nevertheless, they
 153 have a close link with public reforms and policies, since Public Social Security reimbursements
 154 represent more than 60% of their revenues in 2020 [36].

155 We have chosen two cases to reflect the particularities of French private health organisations, a
 156 clinic and a cancer treatment centre (in French *Centre de Lutte Contre le Cancer* - CLCC), both
 157 located in the same region of France (Table 1).

158 The choice of these two establishments is dictated by contrasting contextual and organisational
 159 considerations. These two structures are private and operate in the same health context (public
 160 mission but pursuing different profit and not-for-profit objectives). One is located in a major city,
 161 which can facilitate the professional mobility of the staff of these organisations. The staff have
 162 many public and private health establishments nearby to carry out their activities, unlike the smaller
 163 city in which the clinic is located. This one is characterised by a more limited supply of health
 164 services, which is a limit to the professional mobility of staff in this area. The two organisations
 165 are 70 kilometres apart.

166 **Table 1. Two contrasting cases: CLCC (public mission) and clinic (private for-profit)**

Contextual and organisational factors	CLCC	Clinic
Status	Private, but close to public structures such as university hospitals (care, research and teaching missions)	Private care mission
Connecting entity	Member establishments of <i>Unicancer</i> federation of 20 establishments	Establishment of the <i>Elsan</i> group which is the leading operator of private clinics in France
Location	Conurbation of more than 290,000 inhabitants	Town of 25,000 inhabitants
Organisational specificity	Specialist in the management of cancerous pathologies Model of care for cancer patients	Multi-specialty community medicine and surgery
Number of related professionals	724 102 doctors	212 62 doctors and 150 non-medical staff (caretakers, administrative staff, ...)
Annual number of patients treated	32.000	8000

167

168 **Method of data collection**

169 **Design and recruitment**

170 We adopt for this study a phenomenological approach to explore and describe views of the
171 professionals of healthcare organisations. Phenomenology focuses on how individuals perceive the
172 world [43] in our case how they perceive tensions in healthcare organisations. This method is
173 increasingly used to access the representations of health professionals or patients [44, 45]. We
174 aimed to understand the perceptions and awareness of tensions that affect organisational
175 functioning in two different organisational contexts.

176 We conducted a series of semi-structured individual interviews with 32 healthcare personnel from
177 two French hospitals of different status (clinic and CLCC). All methods were carried out in
178 accordance with relevant guidelines and regulations. The interviews are part of a written research
179 process built in strict compliance with the rules of the ethical charter of the university research
180 laboratory of the authors of the study. The interviews were conducted with the agreement of the
181 management of the two organisations studied and approved by their boards of directors. The
182 experimental protocol used was brought to the attention of the ethics committees of the two
183 organisations studied. The selection of interviewees was made on a voluntary basis from a mailing
184 designed and sent by the management of the two organisations studied. The e-mail sent specified
185 the objective of the study, the modalities of the interview (anonymity, recording, use of the
186 collected data, names and status of the interviewers, duration and location). Interested persons who
187 agreed to be interviewed were invited to contact the researchers by e-mail or telephone to schedule
188 the interview. Our research is a non-interventional research so it is not subject to the rules of the
189 French Jardé law (law n° 2012-300, 2012 March 5th). This category of research based on the
190 collection of individual representations doesn't need a written consent. However, before collecting

191 the discourse of our interviewees for each of them we have detailed our research objective and
 192 methodology to obtain and audio-record oral informed consent from each respondent.

193 Three main categories of staff were investigated: doctors, nursing staff and staff with managerial
 194 functions (coordination, steering, administrative) (Table 2).

195 **Table 2: Respondents in the two organisations**

Clinic			CLCC		
Code	Function	Duration (min)	Code	Function	Duration (min)
Ia1	Care Assistant	42	Ib1	Director of Care	65
Ia2	Human Resources Manager	42	Ib2	Medical assistant	36
Ia3	Financial Manager	39	Ib3	Intensive Care Nurse	28
Ia4	Pharmacist	31	Ib4	Nurse	39
Ia5	Coordinating Officer	44	Ib5	Emergency Doctor	54
Ia6	Doctor	34	Ib6	Medical Secretary	39
Ia7	Anaesthesiologist	54	Ib7	Administrative logistical Manager	42
Ia8	Hospital Services Agent	32	Ib8	Medical Assistant	44
Ia9	Healthcare Manager	27	Ib9	Medical Secretary	37
Ia10	Care Assistant	29	Ib10	Surgeon	48
Ia11	Quality Engineer	44	Ib11	Computer Scientist	57
Ia12	Care Assistant	45	Ib12	Senior Health Executive	57
Ia13	Coordinating Manager	39	Ib13	Imaging Department Manager	51
Ia14	Executive secretary	33	Ib14	Deputy Director	73
Ia15	Nurse	24	Ib15	Doctor	38
Ia16	Nurse (surgery)	29	Ib16	Financial Affairs Director	39

196
 197 **Data collection**

198 Our sample of 32 peoples consisted of 16 professionals from each of the two organisations studied.

199 We conducted semi-structured in-depth interviews at the hospitals (CLCC and clinic location). The
 200 information generated from these interviews was intended to enhance our understanding and
 201 knowledge about governance tensions. Each interview lasted for 24 to 73 minutes. We began the
 202 semi-structured in-depth interviews by asking general questions and gradually introducing more
 203 specific questions about their values, perceived and felt tensions and the meaning given to their
 204 work. The interview guide is structured around four themes: the work environment and its
 205 evolution, the organisational, professional and personal values, the tensions felt or perceived, and

206 the meaning given to work (see additional file). After obtaining the consent of each interviewee for
 207 the recording and transcription of their speech, we transcribed and analysed the 1,293 minutes of
 208 recorded interviews.

209 **Method of data coding**

210 Based on the conceptual framework of PGTs [16, 17], we constructed an analysis grid adapted to
 211 our research question. This allowed us to code our materials (Table 3) in order to identify and
 212 characterise the tensions of public governance present in the two organisations studied.

213 **Table 3. Interview coding grid**

Levels of governance (Mazouz et al, 2012)	Governance tensions (Mazouz et al, 2012. Hudon and Mazouz, 2014)
Institutions (values, beliefs, cultures) Organisations <i>(supply structures)</i> Official management frameworks (laws, rules, procedures) Management tools (HRM, accounting, logistics tools, etc.)	Ethical tensions (in terms of values and standards) Organisational tensions (at the level of work organisation and coordination mechanisms) Managerial tensions (in the application of laws, rules and procedures) Artifactual tensions (at the level of management instruments)

214
 215

216 **Results**

217 Our results highlight the presence of governance tensions at four levels. However, these tensions
 218 manifest differently depending on the characteristics of the healthcare organisations.

219 **Ethical tensions and changing institutional values**

220 In the two establishments studied, we identify ethical tensions linked to the questioning of the
 221 weight of financial constraints, economic viability and compatibility with the public care mission.
 222 The staff are aware of their representations, which are strongly anchored in the values of care.
 223 These values are at the very heart of the health professions. Thus, achieving a different meaning
 224 requires deconstructing the representations according to which good care is not compatible with a
 225 strong focus on the financial dimension.

226 *"We have common representations, common values such as "yes, we provide better care in*
227 *the public sector than in the private sector where profitability and medicine do not mix"*

228 Ib11.

229 These representations largely explain the ethical tensions felt when the term profitability is
230 introduced in the managers' speeches and activity reports. Nevertheless, these ethical tensions are
231 expressed somewhat differently for CLCC staff and clinic staff.

232 In the clinic, the financial dimension is an important issue and a question of the sustainability of its
233 activity, but it is rather well accepted. Managers explain the need to reconcile care and financial
234 performance to ensure the clinic's survival. The staff integrate these values while ensuring their
235 compatibility with the public mission of "care".

236 *"We are asked to do this or that, to review the way we work with patients. I think it's*
237 *essential to have these management tools to be able to explain to the teams why we do this.*

238 *We can't say that we have pressure on the results, but we are aware of what is at stake and*
239 *what the clinic has to do to exist. "Ia9*

240 The professional practices and behaviours of the staff make it possible to reconcile the imperatives
241 of patient care with a rational use of resources.

242 *"I am quite flexible as long as their work is done, ... mutual trust. "Ia3*

243 For the clinic's physicians, *"profitability depends on the best possible quality of care. It is not an*
244 *end in itself"* Ib7.

245 At the CLCC, the values of care prevail over managerial values in this construction. Practices and
246 behaviours are part of a setting where economic performance is very present, but in the minds of
247 the interviewees, the values of the public service mission predominate.

248 *"The advantage of a CLCC is that the management is entrusted to a doctor, unlike a*
249 *university hospital. Production, which is care, is then at the origin of the strategic thinking,*
250 *how to provide better care and not exclusively, how to increase the volume of activity."Ib17.*

251 Although the idea of profitability is very much present in the CLCCs' general management, for
252 them, profitability must be at the service of patients and aims to maintain and perpetuate the
253 medical and care offer.

254 *"The public service character is linked to the fact that we are financed by public money. So*
255 *in this context, because of our mission of collective interest, the profit must not be excessive"*
256 *Ib14.*

257 Thus, at the CLCC, the responses we obtained clearly highlight the values of care as unquestionably
258 dominating those of management.

259 **Organisational tensions generated by the diversity of professional standards**

260 The staff of both establishments report a significant change in working practices.

261 In the care professions, managers and nursing staff note an increasing emphasis on "technical care"
262 to the detriment of "relational care". They seem to regret it but they understand it.

263 *"We are arriving at a new type of care which, in my opinion, has become much more*
264 *technical, standardised, classified and normalised."Ib13*

265 Professional competence is now anchored in a technical skill that is guided by the application of
266 rules and procedures that some find comfortable. These provide a reassuring framework for the
267 exercise, it is that of correct technical gestures and of the control associated with them.

268 *"Confidence is built on technical skills but also on the attitude we have towards the patient.*

269 *The patient needs rigour and humanity" Ib1.*

270 In the clinic, the professional standards that guide the activity of each category of staff are generally
271 accepted. The compatibility of personal values with professional standards depends on the
272 acceptance of the system and the tools for steering the activity.

273 *"Management tools make it easier to accept... heads of department are now able to*
274 *anticipate whether they are actually going to replace a person or not... they say to*
275 *themselves 'I'm going to have heavy patients now, I absolutely have to take on an extra*
276 *person without being afraid of being reprimanded because there is a justification'."Ia2*

277 In this constrained framework (compliance with administrative-financial standards), the
278 respondents underline the challenge they face in reconciling profitability with the best possible care
279 of the patient.

280 *"Yes, profitability is a concern, there may be a temptation to buy cheaper medical devices,*
281 *but you have to keep in mind that it is the patients who are behind it. Balancing the two is*
282 *a challenge for me."Ia4*

283 It seems that all the staff internalise this meaning. Nevertheless, for some of the interviewees, their
284 work is more a manifestation of submission to authority than a true adherence to this meaning.

285 *"The management makes us feel that we have to be profitable, whereas for us the human*
286 *side is more important. It's true that there are tensions at that level."Ia1*

287 For both hospitals, professionalism is expressed in a high level of demands on patients. This is
288 particularly prevalent in discourses for the CLCC where care is particularly complex. This very
289 strong requirement expresses a very pronounced professional commitment.

290 *We have to be careful to live up to our reputation, not to disappoint."Ib4*

291 *"You don't become a carer like you become a mechanic, you have to take care of your*
292 *patients, you have to relieve them, you are a carer" Ib4.*

293 The regulation of organisational tensions is achieved through a stronger focus on professional
294 practices and on patient care rather than on technical standards, although these remain important.

295 **Managerial tensions between practices and professional standards**

296 Within healthcare organisations, cooperation with other professionals and organisations is seen as
297 helping to reduce the risk of tensions on professional practices that the managerial practices of the
298 NPM [34] may cause.

299 However, managerial tensions may persist because, according to the interviewees, in a context of
300 competition, private and public health organisations are seeking to gain patients and market share.
301 This situation leads to limited collaborations that most of them regret.

302 *"We are in direct opposition to the public and private sectors, but we defend the patient's*
303 *pathway. In all cases, the patient goes to the clinic, to the university hospital, comes back*
304 *to the CLCC." Ib1*

305 In the face of managerial tensions between intra- and inter-organisational professional practices,
306 teamwork takes on its full meaning.

307 This is particularly true in the CLCC, because the team plays the role of regulating professional
308 tension by making it possible to objectify a situation and thus to restore value and meaning at work.

309 *"In the oncology sector, there are very strong friendships that develop because there are*
310 *difficult situations to live through and this is part of the life of the organisations. There are*
311 *human stories. "« ... ». The team is a valve when we are experiencing a difficult situation*
312 *in our workplace, the informal exchange times we used to have with the other people in the*
313 *team allowed us to regulate, but today, the reorganisation of the work has reduced these*
314 *spaces that allowed us to talk about our ethical questions" Ib1.*

315 Cooperation with the patient also makes it possible to align the practices of the CLCC's health
316 professionals. The attention paid to the patient as a person and his or her well-being unites the
317 professionals despite the tensions.

318 *"Professionals who remain on the "I know" perspective for the patient and others who have*
319 *understood that the patient has much to teach us" Ib1.*

320 On the other hand, for the professionals in the clinic, cooperation is not spontaneously mentioned
321 as a deliberate practice. It is rather a response to a normative injunction, to a standard that is
322 prescribed by the management. The staff mentioned the difficulty of cooperating with other
323 structures, the reason being the existence of a form of hidden competition (capturing more patients
324 than the "competitor"). This posture nevertheless questions the health and care professionals who
325 are more naturally inclined to cooperate for the benefit of the patient.

326 *"Cooperating would have made sense for all of us. They refused, they were afraid. We will*
327 *still manage without them, but it's sad". Ia4.*

328 **Instrumental tensions modifying professional practices and behaviour**

329 Many professional practices of healthcare staff have had to change as a result of the reforms that
330 have affected healthcare establishments in France since the early 2000s (introduction of activity-
331 based pricing in 2004, the HPST law in 2009, "*Ma santé 2022*", a law enacted in 2019). These
332 reforms have largely contributed to the development of management tools and indicators in the
333 daily work in all its aspects of health personnel (hospital staff, nurses, care assistants, managers,
334 physicians) [46].

335 In the clinic studied, managers use these indicators and management tools to translate
336 management's orientations to the healthcare teams in order to reduce tensions between professional
337 practices and management standards.

338 *"You have to be profitable despite everything, while ensuring quality. The quality of care is*
339 *paramount. But the staffing indicators in my department also allow me to say to management,*
340 *below that, you can't do less, we won't go below that staffing level, it's not possible" Ia5.*

341 Within the CLCC, there is a great need to understand the meaning of management tools and
342 indicators. There is a real questioning about the relevance of the tool but also over its ability to
343 report on situations.

344 *"We have to change our indicators completely because they are obsolete, we have to adapt*
345 *them to changes. I am told that there is an increase in expenditure in my department,*
346 *whereas we have played the game and made savings. I am being charged for expenses that*
347 *are made by the anaesthetists and over which I have no control. "Ib9.*

348 It is up to the CLCC managers to deal with the tensions generated by the financial dimension,
349 which is becoming more and more prevalent. It is their challenge to reconcile management tools
350 with the professional practices of medical and nursing staff. This is a delicate exercise that causes
351 for some of them discomfort, but it is accepted and generally perceived as a necessary challenge to
352 be met.

353 *"We need to increase activity, when I say that to the nurses, it's still disturbing. But I'm fully aware*
354 *that I have to talk about money in my job. But it's also a challenge to my way of looking at things"*

355 Ib4

356 **Discussion**

357 **Three forms of tension, mainly professional**

358 The health governance literature is gradually showing that in health organisations, professionals
359 navigate tensions between their discretionary space, the parameters set by a central decision-maker,
360 and their quest for integration and differentiation [47]. Our results show that the tensions of public

361 governance present [16, 17] in healthcare organisations [9, 22] are expressed in a distinct way
362 depending on the governance mode of the organisations. To our knowledge, this has not been
363 demonstrated in a very illustrative way until now. Moreover, our results show that it is not only
364 protests and resistance [9] that emerge from the discourses, but the capacity of the staff to manage
365 these tensions and to make them liveable, even acceptable [48].

366 The tensions observed concern the four levels of governance (institutional, organisational,
367 managerial and instrumental). The responses made by staff to manage them are strongly influenced
368 by the context in which their organisation operates (Table 4). Our study highlights three main
369 categories of governance tensions that are expressed primarily at a professional level in healthcare
370 organisations: tensions concerning professional values, standards and practices (Table 4).

371 First, the tensions on professional values are mainly described by staff as tensions between care
372 values and financial values. These tensions observed in the two hospitals studied, come from the
373 difficult reconciliation of financial values, particularly those resulting from the hospital reforms of
374 the last 20 to 30 years, with the traditional values of care carried by the health professionals.
375 Tensions regarding professional standards stem mainly from the difficult reconciliation between
376 the technical and relational dimensions of staff. This category of tensions results from the evolution
377 of medical and nursing work towards technical dimensions to the detriment of its relational
378 dimensions between health professionals or with patients. Lastly, tensions on professional practices
379 arise from the difficulty for staff to reconcile the care functions with the administrative functions
380 brought about by the new management instruments. These tensions stem from the development of
381 management tools in healthcare organisations (generalisation of activity-based pricing,
382 development of cost calculation tools, reporting to regional health agencies). These are gradually
383 replacing the managerial practices that until now have been mainly oriented towards the
384 management and steering of care functions (Table 4).

385 However, secondly, these three categories of tension are expressed differently depending on the
386 type of organisation and, in particular, its main management characteristics.

387 In the private for-profit clinic, contrary to all expectations, the analysis of the verbatim reports
388 reveals that tensions related to professional standards are the most important (Table 4). In the
389 interviews, staff emphasised the pre-eminence of technical work standards and procedures in their
390 work and the delicate reconciliation with the relational dimension of their work. This is evidence
391 that these tensions are present and that they guide the ways in which staff act. These tensions are
392 expressed at four levels of tension (institutional, organisational, managerial and instrumental) and
393 the clinic staff respond to these tensions in the following ways:

394 -an acceptance of the search for profitability in order to perpetuate the clinic and its place in the
395 region,

396 - increased professional cooperation and teamwork,

397 - greater negotiation with the management of the establishment with regard to remuneration and
398 the definition of management indicators (Table 4).

399 The staff of the establishment mentioned tensions concerning professional values and practices,
400 but in a much less marked way. They indicate that these tensions are reduced, on the one hand, by
401 a greater translation of steering tools by middle managers and, on the other hand, by the
402 mobilisation of staff's professional beliefs focused on patient care (Table 4).

403 On the contrary, in the not-for-profit public service CLCC, it is mainly tensions on professional
404 practices and, to a lesser extent, tensions over professional values that the staff are required to
405 respond to (Table 4). For these staff, the main tensions arise from the difficult cohabitation between
406 the management tools accompanying public reforms in French healthcare organisations and the
407 care functions attached to the profession of care provider. To a lesser degree, related tensions are
408 expressed between the care values of the staff and the financial values of the reforms. Nevertheless,

409 for the staff of this non-profit organisation, these tensions on professional practices and values can
410 be managed and reduced by:

411 - middle management,

412 - the professional convictions of health workers and their personal commitment,

413 - cooperation between professionals inside and outside the organisation to provide the technical
414 and relational functions of care,

415 -The appropriation of management tools in the professional practices of staff (Table 4).

416 Consequently, the identification of these three forms of tension and their modes of expression in
417 two types of health establishments makes it possible to understand and anticipate the forms of
418 appropriation of health policies in care organisations.

419 In conceptual terms, by analysing the consequences of tensions at four levels (institutional,
420 organisational, managerial and instrumental) (Table 4), the conceptual framework mobilised and
421 our analytical work make it possible to identify tensions arising from the activity of health
422 professionals. By studying the consequences of tensions on professional activity, this analysis
423 completes the one carried out on the causes of tensions [3] which focuses on the managerial
424 tensions of a specific activity (quality management, information management, financial
425 management, etc.). It shows that alongside the tensions caused by each managerial "object", there
426 are also more systemic tensions generated by the overall governance of the health system and the
427 political reforms that are particularly important in France.

428 In practical terms, national policy makers and managers in organisations need to identify and
429 discuss good practice in order to design and implement successful health reforms [7]. Our results
430 demonstrate the need to also integrate an analysis of the risks of professional tensions related to
431 political and managerial decisions in order to build health policies adapted to their implementation
432 context.

433 **Table 4. Governance tensions in healthcare organisations**

Levels of governance	Clinic		CLCC	
	Governance tensions	Responses to tensions	Governance tensions	Responses to tensions
Institutional	Tensions on professional practices	- translating steering tools	Tensions on professional practices	- Role of middle management
	Tensions on professional standards	- Acceptance of the search for profitability	Tensions on professional values	- Role of professional beliefs
Organisational	Tensions on professional standards	- Role of the patient pathway	Tensions on professional practices	- Enhanced cooperation between professionals
Managerial	Tensions on professional values	- Professional beliefs focused on patient care	Tensions on professional values	- Staff sacrifice - Staff commitment to the care profession
	Tensions on professional standards	- Cooperation and teamwork		
Instrumental	Tensions on professional standards	- Role of wage increases - Role of management indicators	Tensions on professional practices	- Appropriation of management tools - Cooperation

434

435 **Different intensities of professional tensions according to the type of healthcare organisation**

436 From a theoretical but also practical point of view, this study allows us to propose a precise

437 distinction between the forms and intensity of governance tensions in healthcare organisations

438 (Table 5).

439 Against all expectations, in the for-profit organisation, which is apparently a less bureaucratic

440 organisation, it appears paradoxically that it is the professional standards (procedures and work

441 standards) that can be the most disruptive for the staff (Table 5). Performance objectives (economic

442 or service quality) and reporting procedures come into strong tension with the relational dimensions

443 of care functions. However, it is also in the face of these tensions that health professionals find the

444 most adaptation, notably by orienting these standards towards patient care. The resolution or at

445 least the reduction of these tensions is more regularly sought through the construction of new

446 professional standards articulated mainly around the patient and his/her care.

447 Tensions on professional values and practices also exist in these organisations but are more
448 moderate. They seem to stem from professional tensions over standards, especially when they
449 require a practical or value-based translation of prescribed procedures.

450 In the not-for-profit organisation, which might on the contrary appear more bureaucratic, it is the
451 professional practices that are the source of tensions, particularly when they neglect the relational
452 dimensions of care work (Table 5). These tensions in professional practices are most clearly linked
453 to the difficult reconciliation between the technical dimensions of care work (medical and
454 organisational dimensions of care) and the relational dimensions. The resolution or at least the
455 reduction of these tensions is sought through greater intra- and inter-organisational cooperation
456 between health professionals. In this case, public reforms or managerial decisions concerning the
457 necessary improvement of medical and organisational practices will be more easily prescribed by
458 encouraging staff cooperation.

459 Tensions on values also exist but are less intense. They are often managed by a greater investment
460 of staff and a gradual appropriation of the financial values of care by the values of care.

461 This distinction between the intensity of these three tensions in the two most traditional forms of
462 healthcare organisation (for-profit and not-for-profit) begins to define a field of research into the
463 effects of modes of governance on the expression of tensions that has so far been little explored in
464 the health literature. Indeed, while the literature has shown in detail that tensions in organisations
465 can arise from the coexistence of different 'modes' of governance (generally characterised by
466 markets, hierarchies or networks) [47], little work has so far shown how these tensions are
467 expressed and how the mode of governance can regulate their intensities.

468 This research focuses on the tensions of intra-organisational public governance, highlighting in
469 particular the tensions generated by the decoupling between the orientations largely stemming from
470 a logic of new public management carried by politicians and the capacities of managers in charge

471 of public service missions who have to comply with the rules of good management and principles
 472 enacted by politicians [48]. A solution can be found in the literature on meta-governance to ease
 473 the tensions. This is based on the ability to involve all actors in the definition of a policy agenda
 474 and of alternative options (network participation) and by reducing destructive tensions through the
 475 acceptance of a flexible adjustment of ends and means (network management) [48].

476 Also, from a managerial point of view, this distinction in the intensity of tensions, for the first time,
 477 also offers managers and public policy makers the possibility to better understand or anticipate how
 478 their reforms or management decisions will influence the work of health professionals.

479 **Table 5. Forms and intensity of professional tensions in healthcare organisations**

Intensity of tensions	Private for-profit healthcare organisation	Public not-for-profit healthcare organisation
Strong	Tensions on professional standards (between technical and relational dimension of work)	Tensions on professional practices (between technical and relational dimensions)
Moderate	- Tensions on professional values (between care values and financial values) - Tensions on professional practices (between technical and relational dimensions)	Tensions on professional values (between care values and financial values)

480

481 **Contributions**

482 This work on the modes of expression of governance tensions in healthcare organisations of
 483 different status presents three contributions, theoretical, methodological and managerial.

484 First, at the theoretical level, this study shows that these tensions are expressed mainly at the
 485 professional level, in three distinct areas: professional values, professional standards and
 486 professional practices. This result complements work on the tensions caused by public policy
 487 changes in the health sector [9, 20, 24]. It shows, on the one hand, that in this sector, these tensions

488 are expressed in organisations mainly at the professional level and, on the other hand, that in
489 addition to the analysis of their causes [3], these tensions are also observable through their
490 consequences on the personnel. At the same time, this study also indicates that, in the private for-
491 profit clinic, contrary to all expectations, tensions around professional standards appear with much
492 greater intensity than those relating to professional values or practices. On the contrary, in the not-
493 for-profit public service CLCC, it is mainly tensions relating to professional practices that dominate
494 and to a lesser extent those relating to values.

495 Secondly, from a methodological point of view, this study has made it possible to construct an
496 initial research method using the contrasting case study to study governance tensions in healthcare
497 organisations. This method can be replicated and tested in future studies, particularly by studying
498 other forms of contrast.

499 Finally, and thirdly, from a managerial point of view, the identification of these three categories of
500 tensions in healthcare organisations offers health policy makers and healthcare organisation
501 managers the opportunity to identify how tensions develop in healthcare organisations and are
502 managed by staff and managers. Addressing these tensions in the design and implementation of
503 health policies is an important issue.

504 In this respect, the responses given to these tensions by the managers and staff of the establishments
505 studied (the role of cooperation, the values and beliefs of healthcare staff, the patient pathways, the
506 translation of management tools by managers - Table 4) represent an intellectual capital [49] [50]
507 that is probably ignored by the leaders of these establishments, but which this study makes it
508 possible to begin to identify as potential tools for the management of tensions in healthcare
509 organisations.

510

511

512 **Limitations and future research**

513 A first limitation of this study is related to the lack of exhaustiveness of our approach, which is
514 limited to the study of two French healthcare organisations and does not allow us to take into
515 account all the contextual specificities of governance tensions. A future step in this work is to carry
516 out other comparative studies to support and enrich the categorisation of tensions proposed in this
517 study. A second methodological limitation concerns the selection of interviewees, which was done
518 on a voluntary basis. Future studies will have to determine whether selection by sampling or
519 randomisation could modify the results obtained.

520 **Conclusion**

521 The purpose of this article was to better understand how governance tensions are expressed in
522 healthcare organisations. The contrasting study of two healthcare organisations, one private and
523 for-profit, the other public service and not-for-profit, allowed us to identify more precisely the
524 characteristics of these tensions. This is a significant improvement in our knowledge of these
525 tensions in healthcare organisations and how they are constructed. Future work already in progress
526 should enable us, on the one hand, to confirm the categorisation of tensions put forward but also,
527 on the other hand, to justify by other explanations their different modes of expression according to
528 healthcare organisations.

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645 **Declarations**

646 **Ethics approval**

647 The experimental protocol used was brought to the attention of the ethics committees of the two
648 organisations studied (Centre Jean Perrin Clermont-Ferrand - France, Polyclinique La Pergola -
649 Vichy - France). Our research is non-interventional and therefore not subject to the rules of the
650 Jardé law (law n° 2012-300, March 5, 2012) on biomedical research conducted in France. This
651 category of research based on the collection of individual representations of health facility staff
652 does not require written consent by it just requires information of the ethical committees from the
653 two organisations, which was carried out.

654 Concerning the protection of personal data, in the European Union and in France, the General Data
655 Protection Regulation (GDPR) (Regulation 2016/679 of the European Parliament and of the
656 Council of 27 April 2016) came into force on 25 May 2018. The French Data Protection Act (Law
657 No. 78-17 of January 6, 1978 on information technology, files and freedoms) has been adapted
658 accordingly by the Personal Data Protection Act currently being enacted. These two texts now form
659 the basis of the new regulation on personal data protection. The GDPR defines personal data as
660 "any information relating to an identified or identifiable natural person", i.e. a natural person who
661 can be identified, directly or indirectly. In practice, this may include identification data such as
662 surname, first name, address or telephone number, information relating to the patient's personal life
663 (e.g. number of children), social security coverage (e.g. compulsory health insurance,
664 supplementary health insurance, etc.) and, above all, information relating to the patient's health
665 (pathology, diagnosis, prescriptions, care, etc.), and any professionals involved in his or her care.
666 In our study, we do not use any of these data because they are only interview data with health care
667 staff for which no identification of individuals is mentioned. The data used relate only to the
668 individual perceptions of staff at the two healthcare facilities studied and do not present personal
669 information about the respondents.

670 **Consent to participate**

671 Oral informed consent was obtained from all participants at the beginning of each interview and
672 recorded. Each participant also verbally consented to the audio phonic recording of the interview.
673 The interviews were conducted with the agreement of the management of the two organisations
674 studied. Permission to conduct the staff interviews was obtained directly from the chief executives
675 of the two organisations studied in agreement with their boards of directors. The interviewees were
676 interviewed on a voluntary basis.

677

678 **Consent for publication**

679 All authors have seen and approved the manuscript and contributed equally for the paper. They
680 consent to the publication of this article if it is accepted.

681 **Availability of data and materials**

682 The datasets used and/or analysed during the current study available from the corresponding author
683 on reasonable request.

684 **Competing interests**

685 The authors report no conflict of interest

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688 or not-for-profit sectors.

689 **Authors' contributions**

690 L.M. presented the conceptual framework. C.R. presented the methodology. L.M and C.R. coded
691 the results. C.R. extracted the results. L.M. and C.R. discussed the results and wrote the conclusion.
692 L.M. and C.R. formatted the manuscript.

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