Necessity of Changing Modes of the Traditional Hospital Governance

Tahar L. Ayed
School Of Commerce (ESCs), Sfax, Tunisia
College of Business, Umm Al-Qura University, KSA
Email: thayad@uqu.edu.sa

Rim H. Hajlaoui
National School of Admnistration, Tunis, Tunisia
Email: rim_haoues@yahoo.fr

Amira H. Ayed
Department of Management, Higher Institute of Technological Studies, Nabel, Tunisia
Email: amirahaoues@gmail.com

Osama M. Badr
Faculty of Commerce, Tanta University, Egypt
College of Business, Umm Al-Qura University, KSA
Email: ombadr@uqu.edu.sa

***Abstract*—The main objective of this research work is to demonstrate the necessity of changing modes of the traditional hospital governance. These modes are characterized by logic of specialization and a segregation of tasks, a power of competence and a broad autonomy of doctors releasing them from the need to coordinate their activities with those of their colleagues. The new mode of governance leads to a real capacity of initiative and an empowerment of hospital practitioners. The renovated organization offers an opportunity to engage in a real integration of different medical and administrative logic and a reconciliation of professional cultures that promote a synergy of skills, resources and, therefore, optimize resources allocation and improve the quality of care. The aim is to ensure better coordination between the medical sphere and the administrative sphere, in order to make the hospital system work faster and better.**

***Index Terms*—hospital governance, hospital system**

I. Introduction

The action of any organization depends on the individuals who compose it and their orientations; this is especially true in hospital organizations, characterized by the complexity of the decision-making process and the multiplicity of stakeholders.

In addition, the last few years the world of health care has undergone several upheavals, which were at the origin of reorganization in the functioning of health facilities. Meanwhile, the hospital uneasiness cannot be explained only by the evolution of economic constraints or social pressure, but also by a profound transformation of the production system itself which is becoming increasingly complex.

There has, therefore, an increase in the volume of interactions between professionals in the care of patients and an increase in collective modes of operation, hence the need for better coordination between various stakeholders in the process of care, and also between the medical healthcare sphere and administrative sphere, in order to better manage hospital organizations at the long term.

At this level, it should be noted that the modes of "traditional" hospital organization will be inappropriate to a logic of deconcentration and participatory management and do not seem to encourage the involvement and participation of all stakeholders hospital world. So it is about to change the organization of the hospital to ensure better management of activities and a renewed governance.

II. The Economic Importance of Medical Institutions Governance

The objectives of governance is to improving performance through fight financial and administrative corruption in the medical institutions, in addition to the application of the principle of good morals and good transactions humanitarian and economic ties between dealers with medical institutions and ensure aspects of ethical work in medical institutions. Thus, reflected the

Manuscript received January 5, 2014; revised April 25, 2014.

doi: 10.12720/joams.3.1.60-66

application of medical institutions governance is well on the performance of medical units in its various dimensions of its functions in community service efficiency [1].

Adopting governance methods has economic importance, which was confirmed strongly by Winkler , as pointed out to the importance of medical institutions governance in achieving economic development and avoid falling into the financial crisis, through the consolidation of a number of performance criteria, including working to strengthen the economic fundamentals in the market, and to detect fraud and corruption, bribery and misuse management, including Leading to earn trust of coefficients of community [2].

The economic importance of medical institutions governance, including the following :

Raise the efficiency of use of available resources, which achieves to improve performance, maximize profitability and thus create new jobs, which contributes to the reduction of unemployment and its negative effects on society as well as the stimulation of labor in the company and improve their production rates.

Improve and develop administrative staff, including contributing to the strategic decision-making best suited according to the current conditions and expected and thus ensure the rights of community and public authority and raise the level of competitiveness between medical institutions thereby increase Effective performance.

Achieve a balance of interests between public authority and workers on the one hand and managers on the other hand, including contributing to the stimulus to raise the performance and thus increase revenue and reduce costs.

The provision of a comprehensive control system ensures accountability for negligence and prevents waste in medical institutions funds to contribute to lowering costs.

III. The Hospital as a Complex Organization

The complexity of hospital organization is associated with the coexistence of several logics that are sometimes contradictory and emanating from the multiplicity of actors within the hospital. Meanwhile, this complexity is enhanced by the presence of a constantly evolving technology. Indeed, the hospital provides cares that are more or less specialized and require, therefore, a complex technique tray. In addition, the hospital environment is not immune to the changing environment in its different technological, economic, demographic or political dimensions.

A. Historique and Definition of the Hospital

The concept of the hospital has evolved over time both in The Western and Oriental countries, from a simple shelter for the poor to a place of a high-tech care. The concept of the hospital finds its origins in the Latin literature, in fact, it comes from two words “hospites” which means “host” and “hospitalisdormus” which means “house where guests are received”, the hospital has the same etymological origin as host, hospitality and hotel [3]. In addition, it is a plural concept with multiple stories and multiple meanings. In the West, it started as a center of social assistance and has become a preferred place of care and professional practice at the end of the 19th century. By cons, in Arab and Muslim countries, the history of hospitalization is confused with the development of “Bimaristanes” whose model is different from the Western General Hospital. The primary function of “Bimaristane” was related to the hospitalization of battles’ casualties. Moreover, this notion is of Persian origin and comes from “bimar” meaning sick and “stan” which means place or house [3].

The experts committee of the Medical Care Organization (OSM) defines a hospital as “an element of a medical and social organization whose function is to provide to people full, curative and preventive medical care and whose external services irradiate to the family considered as a medium, it is also a medicine teaching and bio-social research center” [4]. Then, a more practical and wide definition was adopted by the World Health Statistics Yearbook to be applicable to all types of hospitals developing and highly industrialized countries. In fact, the hospital was defined as an establishment where patients are accommodated receiving medical and nursing care. In this regard, it should be noted that for such an establishment to be considered as a hospital, its permanent staff should include at least one physician [5].

Meanwhile, the hospital may have additional responsibilities. Indeed, it can be used to train health personnel and conduct research on medical, epidemiological and social problems. In addition, the hospital is “a living organization with a strong collective identity and a real autonomy that many other public entities don’t have” [6]. For Kervasdoué (cited in research works of Pellerin), “the hospital is, by nature, a complex organization with multiple roles, actors, technical and often contradictory expectations of the public and authorities” [7].

Moreover, the complexity of the hospital organization could be explained by the fact that the technology is very present in the hospital and is in constant evolution. Similarly, actors are numerous and professional cultures are strong, which make many logical that are sometimes contradictory [8].

B. The Hospital Environment as a “World of Professionals”

The hospital is a place where coexist several types of professionals with a high level of skills and enjoying a high degree of autonomy. This allows them to contribute to discussions on improving the daily operation of various services in order to provide patients care quality. In addition, the hospital environment is “a world of professionals in which doctor is considered as a key figure in the operating system of a hospital. On the top of the symbolic hierarchy, doctors form a world apart, and represent the model of accomplished professional, making advanced technical competencies”.

It would appear thus that doctors are the "heart" of the hospital; however, they often identify themselves with their service, discipline and profession, much more than

with the hospital. They often tend to neglect the needs, goals and interests of their establishment [9]. The hospital is a structure where the main actors are professionals with specific and unique skills and complex knowledge, this tends to give them considerable autonomy in diagnosing situations and implement solutions. In addition, the breadth of knowledge required to the medical activity and the high degree of expertise necessary to make appropriate and timely decisions are likely to make inappropriate design procedures for the production of health care by external actors to the profession [10]. However, the diversity of hospital trades and professional cultures could be a barrier to the achievement of good medical practices. Indeed, the plurality of actors within the hospital is causing different logics that none of them can be may be excluded. Thus, the hospital appears as a place of divergent views where the multiplicity of interests, often antagonistic, hampers the functioning of the hospital. In this regard, the management appears as an art that combine and integrate different approaches in order to achieve collective projects [11].

In this regard the managers of hospitals have opted to search for new objects of government, relations between actors they are Shareholders or stakeholders, and new tools in other words, the hospital governance that contributes to defining an overall objective with management arrangements. Indeed, the diversity of actors is a source of heterogeneity of objectives and interests in the hospital. At this level, it should be noted that in the hospital environment, there are several modes of governance that determine the sharing of responsibilities and manage the relationships between the different hospital actors.

IV. The Hospital Governance

Hospital governance can be defined as the set of "systems and practices that enable stakeholders to develop a plausible representation of their future, connect and implement effective change strategies and rely on generating trust and solidarity values. Governance refers to the organizational design of health care and the sharing of responsibilities and capabilities of influence among the different entities that compose; it refers too to the systems and mechanisms of production and dissemination of information and modalities for funding organizations and professionals". [12].

Thus, in contrast to corporate governance where the objectives are control of managers and the primacy of the interests of shareholders, hospital governance must be strategic governance, project governance, and therefore involve all relevant actors [12].

Hospital governance means that the top priority is now given to the clinical activity, provided that everything is done to continuously improve the quality of services rendered to patients establish the highest standards of clinical practice [13]. In other words, it is a framework through which organizations are held accountable for continuously improving the quality of their services must ensure high standards of care.

Hospital governance means that the top priority is now given to the clinical activity, provided that everything is done to continuously improve the quality of services rendered to patients and establish the highest standards of clinical practice [13]. In other words, it is a framework through which organizations are held accountable for continuously improving the quality of their services and must ensure high standards of care.

Specifically, it is about putting in place new driving skills to better understand what is produced, the impact of interventions and actions taken and the benefits agreed between professionals and organizations decisions. Indeed, "clinical governance consists in mobilizing a set of levers (incentives, information, authority) to assure essentially collective nature of medical activity and to ensure the updating of clinical practice based on the knowledge available" [14].

Clinical governance aims to study the relationships between the different actors, contribute to establish an organizational and participative managerial clinical purpose. It comes to rely on both competencies of the various participants and the ability of organizations to direct and coordinate actions for a better arrangement of all resources and improving the quality of services and care.

The hospital organization, like many other organizations, is characterized by asymmetric information and opportunist behavior emanating from the plurality and diversity of actors. In fact, the hospital is a place where several stakeholders who do not necessarily have the same interests exist. In this perspective, hospital governance appears as "a struggle device against information that marks the production and distribution of care and services" [14].

Furthermore hospital organizations are characterized by the complexity of decision making processes and the plurality of stakeholders. In addition, in recent years, the world of health care has undergone several upheavals, that caused reorganization in the functioning of health facilities. Hospital unease cannot be explained only by the evolution of economic constraints or social pressure, but also by a profound transformation of the production system which is becoming increasingly complex.

We are witnessing, therefore, an increase in the volume of interactions between professionals caring for patients and an increase in collective modes of functioning, hence the prevalent need for better coordination between various stakeholders in the process of care, but also between the medical healthcare sphere and administrative sphere, so as to better manage hospital organizations over the long term.

At this level, it should be noted that the modes of "traditional" organization of the hospital will be inappropriate to a logic of devolution and participatory management and do not seem encouraging the involvement and participation of all stakeholders of hospital environment. So it is about to change the organization of the hospital in order to ensure better the management of the activities and a renewed governance.

Thus, the proposed reorganization of hospitals that is called "new governance" should now mark the desire to rationalize the clinical activity, promote collective logic around the patient and involve hospital practitioners in the management of the institution, hence the necessity of changing "traditional" modes of governance.

V. Characteristics of "Traditional" Governance Modes

A. Professional Bureaucracy

The organizational model considered by many researchers in hospital management as instructive to describe the internal functioning of the hospital is the model of "professional bureaucracy" of Mintzberg. Unlike other structural configurations, "the professional bureaucracy recruits trained and skilled specialists-professionals-for its operational center and let them considerable latitude in controlling their own work" [15].

At this level, it should be noted that the operational center constitutes the key part of the professional bureaucracy. Indeed, a large share of staff employed by the hospital is comprised of doctors who have specialized expertise upon which base the institution to organize its work [15].

Furthermore, the model of the professional bureaucracy involves two main actors namely the medical profession and the management of the establishment, each with specific areas of power. In this model, the distribution of power is uneven; moreover, the complexity of the tasks performed and the social importance of medical activity tend to give the medical profession a stronger influence power over the director.

In fact, the autonomy of doctor in relation to the hospital institution is great, and his decision-making depends less on his position in the hospital hierarchy than of belonging to the medical profession. In addition, the activity of care and treatment of patients is more socially valued than the administrative and financial management of an institution [16].

In this context, it is worth mentioning that in professional organizations, administrators are responsible for secondary and support activities insofar as they manage the resources made available to the principal activity of experts. Thus, in such structures, the final decision remains with professionals [17].

The professional bureaucracy is "a highly decentralized structure both vertically and horizontally. Much power over the operational work is located at the bottom of the structure and shared by professionals of the operational center" [18].

B. Separation between Medical and Managerial Activities

The hospital organization is characterized by a separation between, on the medical world whose main role is to treat and the world of managers whose mission is to manage the resources required by the medical activity [19]. In this vein, Mintzberg and Glouberman [10] noted the lack of effective communication between these two worlds. Moreover doctors were aware of their activity to their peers, even to patients, but rarely or never to managers, that is to say in terms of efficiency [20].

By their expertise, their training and specialization doctors work very individually and can pursue specific objectives with their profession which does not necessarily correspond to the overall objectives of the hospital establishment [21]. This could be explained partly by the fact that their income is independent of the willingness of the administrator since it is only provided by the guardianship. In fact, the director did not reward the effort of the doctor monetarily, by cons, he is responsible to allocate a budget to the different responsibility centers [22].

In the same vein, the lack of cooperation between professionals and managers could be explained by the fact that on the one hand, doctors say that the organization they are often described as bureaucratic administration hampers the achievement of good medical practice and secondly, managers denounced the autonomy of health professionals that they fluently call inertia [19].

C. Divergence of Interests of Doctors and Managers

Studies conducted by several authors have shown that there is a relationship of conflict between managers and doctors [23]. Moreover, although these two groups gather around a common interest namely the success of the hospital, they do not quite agree on the meaning and how to measure success.

Some are blinded by the technical performance and the delivering of quality care; others are concerned to optimize the allocation of resources. Thus, the values they prefer are different or even opposite [24] as the director's interest is generally to achieve a balanced budget while hospital doctors most often seek therapeutic optimum [22].

And parallel with the stretch between medical and administrative staff, respectively coexist two logics: the logic of the profession and the logic of the institution, the first derives its legitimacy from the knowledge, the second from the public interest. Thus, the distinction between the two logics of professional belonging make up the main difference between both bodies: the members of the administrative sphere prefer the logic of the institution while the members of the medical sphere put first the logic of the profession. In this regard, studies have shown that lack of communication and collaboration between doctors and managers is one of the internal factors affecting the relationship between these two actors within the hospital organization [23].

D. Reticence of Doctors to Integrating Management Practices

As part of their professional practice and their relationships with patients, doctors generally have no knowledge of the constraints of the institution where they do their job and do not always perceive the institutional issues of the hospital especially if they do not participate in any proceedings [25]. As such, resistance or immobility may appear merely because of ignorance of the economic logic and understanding of its application in

the care [26]. Indeed, hospital doctors struggle to integrate economic and social dimensions that are not part of their traditional professional culture, which is likely to provoke their much reluctance or resistance that might hamper the process of the manager at the hospital [27]. Thus the design manager of medicine often causes a reaction of rejection among practitioners who are kept to single care service providers [22] status.

In this regard, it is noted that the new hospital governance may not be applied in a traditional organization strongly rooted within which the current rationalization clashes with resistances of its stakeholders. In small establishments and in particular local hospitals, care teams can have behavioral reluctance towards the adoption of management practices and even islets of resistance to managerial logic [28]. Doctors feel most often foreign with the management principles and think it is for the administration to manage the logistical, financial and organizational issues. Thus, the administrative world is essentially seen as a support service that doctors used in case of problems or to obtain financing.

VI. Necessity of Changing Modes of "Traditional" Governance

A. Willingness to Control Costs

Health establishments are often described as a ground of confrontation between caregivers, including the medical sphere and non-caregivers namely the administrative sphere: the first deplore bureaucratic mind of the administration, its ignorance of the realities on the ground, the latter complain about fiscal unawareness which reigns in the health care services and obsession for technical performance that blinds the minds of caregivers. At this level, it should be noted that the aim of controlling costs requires the reconciliation of both administrative and medical spheres whose objectives are different, even antagonistic [22].

Thus and knowing that the decisions of doctors are responsible for a large share of resource utilization and turnover of hospital, managers tend increasingly to influence medical practices to increase the efficiency of the health care facility: ultimate objective of the new hospital governance [29].

Specifically, it is more closely associated the management of resources (resources, costs, activities) those who, through the responsibilities they perform and influence directly the evolution of costs and activities. It is therefore an issue to implement more efficient organizations, control costs, to reduce bureaucracy and to develop professional responsibility of actors [30].

B. Searching for a Synergy of Competencies

The gap between the administrative sphere and the medical sphere is more hollower when the responsibility for the quality of care should be shared by all staff of the hospital. It is, therefore, a matter of practicing a multi professional process involving multiple actors and involving cross-specific and transversal competences to ensure the success of the care facility. Moreover, in the work of Bouvier [31], the new governance is not limited to a simple change of style and seems to be a learning management system that invites actors to be less passive, more responsible and more cooperative. It comes to seek an integrating structure based on a collective logic taking into account the expertise of the different categories of actors and inducing more decentralization structure. Therefore, clinical governance is conceived as integrated and multi-level governance that is to say a means for the integration of different logics–within the hospital organization [32].

To improve the quality of care, some authors suggest creating an alignment between the different levels of care namely the individual, team, organization and the system [33]. The principles of clinical governance are trying to produce some synergy involving professionals in the renewal of the organization and involving the organization in the regulation of professional practices in relation to different levels of care.

C. Towards a Better Management of Conflicts

The hospital is a complex organization that includes several actors; each one is pursuing his own interest. This complexity is due to the diversity of stakeholders in the institution. The hospital is torn between the interests of its stakeholders as they are doctors, managers and patients. In fact, these actors are pursuing divergent interests [34].

At this level and given the existence and multiplicity of disagreements, "hospital governance heralds the emergence of a renewed professional organization" [14] to ensure the quality of health care expected to meet the needs of the institution and to ensure sustainability.

Moreover, in an environmental context increasingly marked by instability, succession of crises and the gradual withdrawal of the state, the hospital is like any other economic entity should now respond to a level higher quality and to challenge the competence, efficiency and performance.

But this cannot happen without the deliberate intention of all stakeholders to overcome and better manage potential conflicts by dealing with each other. Moreover, some authors state that "several managers can Implement Strategies to improve doctor-manager relationship, Including students organizational Greater transparency in decision making and more frequent communication" [35].

VII. Conclusion

The hospital is of a very special operating system showing a separation between medical and managerial activities so that the complementarily between the two spheres is seen as a minimum base activities.

In addition, doctors often feel foreign to management practices and thereby experience a reluctance or immobility pushing them to concentrate on their professional field and to reject any managerial design of medicine. This is, therefore; likely to further accentuate the divergence of interests of doctors and administrators. The new hospital governance appears as a supporting opportunities radical solution that aims to improve patient care, streamline the allocation of financial and budgetary

resources to ensure better management of medical and nursing skills and allow management closer to the practice ground. So to succeed the new hospital governance, it is not enough to be limited to a simple transfer of responsibilities and a change perimeters of actions, we will have meet some factors favoring the adoption of new principles. It is therefore a question of putting in place arrangements for training doctors in the management; develop a culture of cooperation and collaboration to establish a hospital information system to facilitate good communication.

REFERENCES

[1] S. Alhefnawy, "Corporate governance and its role in the treatment of accounting thought," in *Proc. Annual Scientific Conference the Fifth, the Faculty of Commerce*, Alexandria University, Sept. 2005.

[2] S. Nuriand, "Corporate governance and its role in reducing the problems of agency theory," *International Forum on Creativity and Organizational Change in Modern Organizations*, Iraq, vol. 18, May 2011.

[3] B. Alaoui, "General principles of strategic planning in the hospital," *Internal Publication, Ministry of Health*, Morocco, 2001.

[4] "Report of the expert committee of the World Health Organization (WHO)," *Technical Report Series*, no. 122, 1957.

[5] "Report of the expert committee of the World Health Organization (WHO), series of technical reports," *Administration Hospitals*, no. 395, 1968.

[6] B. Brouard, "The impacts of management control in the French hospital universe," M.S. thesis, Work Sciences and Society, Human Resource Management and Sociology, *National Conservatory of Arts and Crafts*, 2005.

[7] D. Pellerin, "Medical errors," *Tribunes of Health*, vol. 3, no. 20, 2008.

[8] N. Juilliard-Fournier, "The hospital organized in clusters: Opportunities and challenges for the director of care," *Memory of the National School of Public Health NPHS*, 2002.

[9] F. Djellel, C. Gallouj, F. Gallouj, and K. Gallouj, "The innovative hospital, from medical innovation to service innovation," *Massons Editions*, Paris, pp. 1-3, 2004.

[10] J. C. Moisdon, "Clinical governance and organization of care processes: A missing link?" *Practice and Organization of Care*, vol. 39, no. 3, July-Sept 2008.

[11] F. Champagne, J. L. Denis, and H. Bilodeau, "Medical and hospital interests: Conciliation will it be?" *Ruptures, Transdisciplinary Journal Health*, vol. 5, no. 1, pp. 53-61, 1998.

[12] G. Dechamps and C. Romeyer, "Trajectoires d'appropriation des principes de la nouvelle gouvernance hospitalière par les médecins," in *Proc. 15ème Conférence Internationale du Management Stratégique, Annecy-Genève*, pp. 22, June 13-16, 2006.

[13] J. M. Chabot, "Clinical governance," *French Anales of Anaesthesia and Intensive Care*, vol. 24, no. 1, 2005.

[14] J. L. Denis and A. P. Contandriopoulos, "Clinical governance: Discussion and perspectives," *Practices and Organization of Care*, vol. 39, no. 3, 2008.

[15] S. Debrat, "Specialties performance management professionals," M.S. thesis, presented at the Faculty of Graduate Studies, University of Montreal, 2007.

[16] A. P. Contandriopouloset and Y. Souteyrand, "The strategist hospital: Local dynamics and provision of care," *John Libbey Eurotext*, Paris, pp. 317, 1996.

[17] A. Etzioni, "Authority structure and organizational effectiveness," *Administrative Science Quaterly*, vol. 4, no. 1, pp. 43-67, 1959.

[18] H. Mintzberg, "Structure and dynamics of organizations," Montreal Paris, Éditions organization, Arc Publishing Agency, 1995.

[19] M. Robelet, "The bottom of the clinical governance: The entrance of the hospital in the audit society," *Practices and Organization of Care*, vol. 39, July-Sept 2008.

[20] J. P. Dumond, "Conflict of powers in the hospital," *Tribunes of Health*, vol. 1, no. 1, 2003.

[21] D. Durieux, "Decentralization of hospitals: A challenge for the management of human resources," *Hospital Journal*, vol. 3, no. 246, 2001.

[22] J. P. Domin, "The new hospital governance: Theoretical foundations and applications," in *Proc. Communication Symposium Political Economy of Governance*, CEMF, University of Burgundy in 2006.

[23] T. Rundall, H. Davies, C. L. hodges, and M. Diamond, "Doctor-Manager relationships in the United States and the United Kingdom," *Journal of Healthcare Management, Chicago*, vol. 49, pp. 251, 2004.

[24] P. Degeling, K. Zhang, B. Coylea, X. Lingzhong, Q. Mengc, J. Quc, and M. Hill, *Clinicians and the Governance of Hospitals: A Cross-Cultural Perspective*, 2006.

[25] Y. Lequet, "The hospital organized on medical poles, learning new governance," *Memory of the NPHS*, 2005.

[26] L. Amiar, "The hospital: Dialogic between cost and humanity, to the appropriation of a new healthcare culture," M.S. thesis, Professional Education and Training, 2005.

[27] C. Merdinger-Rumpler, "Identification of organizational and cultural barriers to the process manager in the French public hospital. The case of management tools of patient satisfaction," *Journal of Medical Economics*, vol. 26, no. 3, pp. 127-139, 2008.

[28] S. Divayet and C. Gadea, "The health managers face the managerial logic," *French Review of Public Administration*, vol. 4, no. 128, 2008.

[29] G. Launay, C. Molina, P. Filhol, and T. Negre, "Device and assessment of the new governance of University Hospital of Montpellier," *Journal of Medical Economics*, vol. 26, no. 1-2, 2008.

[30] E. Viitanen, J. Lehto, T. Tampsi-jarvala, K. Mattila, I. Virjo, M. Isokoski, H. Hyppölä, E. Kumpusalo, H. Halila, S. Kujala, and J. Vänskä, "Doctor-Managers as decision makers in hospitals and health centres," *Journal of Health Organization and Management*, Bradford, vol. 20, pp. 85, 2006.

[31] P. Peyré (2006). The competency of to be a "health manager": In-between governance training and networking the relations between individuals. [Online]. Available: http://www.afscet.asso.fr/resSystemica/Pau%202006/PeyreTXT.pdf

[32] C. Pascal, "The challenges of integrated clinical governance," *Practices and Organization of Care*, vol. 39, no. 3, July-Sept 2008.

[33] I. Brault, D. A. Roy, and J. L. Denis, "Introduction to clinical governance history, components and conceptualization renewed for improving the quality and performance of healthcare organizations," *Practice and Organization of Care*, vol. 39, no. 3, 2008.

[34] E. Minvielle, C. Sicotte, F. Champagne, A. P. Contandriopoulos, M. Jeantel, N. Preaubert, A. Bourdil, and C. Richard, "Hospital performance: Competing or shared values?" *Health Policy*, vol. 87, no. 1, pp. 8-19, July 2008.

[35] C. L. Hodges, H. Davies, and T. Rundall, "Doctor-manager relationships in the United States and the United Kingdom," *Discussion*, vol. 49, pp, 251-68, 2004.

Tahar Lazhar Ayed is a Canadian born in Tunisia in 1973. He received his B.Sc. in economics and Social Sciences from Tunis El Manar University in 1997 and his MBA in Marketing and Data Analysis from the University of Quebec At Montreal, Canada in 2002. He earned his Ph.D. in Business strategies from Tunis Al Manar University in 2009. The Research Thesis is done under the supervision of Canadian and Tunisian professors. He is now serving as an Assistant Professor (Visitor) of Strategies and Data analysis in College of Business at Umm Al-Qura University, KSA where he joined in 2012. He works as a Marketing Manager at CFH Security in Canada from 2000 to 2004, a Lecturer in the School of Economics and Commerce (Tunis, Tunisia) from 2004 to 2006, a lecture and assistant Professor in the School Of Commerce (Sfax, Tunisia) from 2006 to 2012. He teaches Principles of Management, Data Analysis, Research methodology, cost accounting, etc. Dr. Ayed has published books and scientific papers in different journals.

Rim Haoues Hajlaoui is Tunisian student in National School of Administration, Tunisia. She holds a master degree and a bachelor degree in finance.

Amira Haoues Ayed is Tunisian. She has been a technologist teacher since 2005 at Higher Institute of technological studies in Nabil, Tunisia. She holds two Master's degrees in Management and Management of Higher Education Institutions.

Osama M. Badr is a Canadian born in Egypt in 1964. He received his B.Sc. in economics from Tanta University 1986 and his MSc in applied economy from Tanta University 1998. He earned his Ph.D. in economics from the same university in 2007. He received his diploma of financial analyst for Stocks, Bonds and other investments, Concordia University, Montreal, Canada, 1997. He is now serving as an Assistant Professor of Economics (Visitor) in College of Management at Umm Al-Qura University, KSA where he joined in 2011. He works as Economics Lecturer in Tanta University since 2006, He worked as Economics Assistant lecturer from 1999 till 2006, financial analyst 1993 to 1997, Credit Supervisor in Bank of Credit and commerce from 1987 to 1993. He teaches Principles of Economics, macroeconomics, Public finance, Fiscal Policy, Money and banking, International Economy and foreign trade and Modern economic problems by relating theories to his six-year experience in banking industry and ten years in financial analyses. His research interest focuses on economic policies and economic growth of developing economies. He has published one English book on Fiscal Policy and five Arabic books (Public finance, Fiscal Policy, Money and banking, Foreign trade and Modern economic problems). His papers have been accepted in numerous local and international conferences. Dr. Badr is a life member of Egyptian Economic Association and Canadian Economic Association.