Institutional Change: Alignment And Organisational Development in a French Hospital using Collective Action

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ABSTRACT

Nowadays, change management is becoming an increasingly essential concern for various companies all over the world. The restructuring of complex organizations, as those in the healthcare industry, is highly influenced by recent economic, technological and regulatory changes in health sectors. To understand the impact of these restructuring movements, one must analyze the changes affecting the various hierarchical levels of the healthcare organization. Under the French socio-economic context, healthcare institutions are currently undergoing multiple strategic and operational transformations, which require professionals to adapt their skills and capacities accordingly. In fact, the impact of medical, technical and digital innovations is driving the concerned structures to emphasize value in their adaptations. For a successful implementation, it is necessary that concerned parties intervene. These latters are then encouraged to focus on updating the organization's strategy, improving human resources development and adjusting necessary patterns and processes. Therefore, this research relies on analyzing organizational performance from a collective action perspective. We aim to examine the managerial expectations of a study sample of managers, professionals, and staff in a French hospital undergoing full reconstruction. To this end, a qualitative and experimental approach are applied to identify the difficulties and understand how this sample participates in optimizing the hospital’s structure and eventually optimizing the patient experience.

Keywords: change management, healthcare institutions, patient experience, collective action, managerial expectations
1. INTRODUCTION

During the last decade, restructuring healthcare system is an international preoccupation. The system’s restructuring can be carried out from several economic and social evolutions. Controlling deployments and managing the organizations are the two challenges to which the healthcare institutions are confronted. In order to improve the collective performance, UK National Health Service (NHS) developed in 1990 the concept of the clinical governance. This latter has been one of the main factors in improving the healthcare system. Therefore, healthcare organizations are requested to use the governance system to improve their services quality. Furthermore, the globalization exerted several pressures on the states, more precisely on their public finances. These pressures have imposed a budget control for the healthcare system. For this reason, the concept of clinical governance is spread worldwide.

Clinical governance concept is too extensive. It is characterized by audits, risk management, patient engagement, learning, data practice and the relation between professionals and patients (Veenstra et al., 2017). These elements are based on the ethics of health professionals such as teamwork, leadership, communication and knowledge. This governance concept considers the health professionals as principal actors which contribute to the improvement of the healthcare quality. In this context, clinical governance studies the balance between top-down and bottom-up approach. This balance allows professionals to valorize their participation. In addition, governance is defined as the design, conduct and evaluation of collective action from an authority position (Hatchuel, 2000). Therefore, reforming health system becomes essential, which implies reforming healthcare institutions. Hence, the study deduce that governance concept allows to change.

In this perspective, management organization requires an active contribution of different actors, such as managers and professionals. Thus, hospitals restructuring and digital evolution can induce several problems of professional adaptation. These reforms require the creation and the update of several type of jobs or skills. These latters need to be redefined at different levels, such as qualifications, trainings and career management. In order to understand these changes, it is essential to identify the nature of the restructuring effects. In fact, it is important to explore the restructuring dimensions which affect individuals, collectives and organizations.

In healthcare institutions, patient is defined as the primary person which is concerned by the healthcare. Actually, the hospital challenge is to optimize the overall patient care. In order to achieve this objective, the hospital need to improve its information system. This can be done by the following actions:

- Listening to the patient,
- Supporting and preparing the patient experience,
- Collecting the necessary information for patient care,
- Answering the patient’s questions while ensuring the information research and proposing solutions,
- Providing the patient with additional services in order to satisfy his requirements.

For that purpose, restructuring services is a real opportunity to improve these actions and manage an innovation project. These actions will fulfill the patient’s satisfaction and the hospital goals. They will allow the hospital to optimize the patient experience. Therefore, optimizing the patient experience responds to structural, organizational and human requirements. Consequently, an interaction between the different institution services (Human Resources, strategy, finance…) is needed. These services are able to redefine a coherent model, while respecting simultaneously the
existing constraints and resources. Implementing this model generates several changes in the teams’ tasks and roles. It requires new spaces and technologies in order to provide new knowledge and practices. In addition, these changes require a real human resources support.

The patient experience is the main image of the hospitals. In this paper, we explore the managerial expectations of the hospital’s reconstruction from a patient experience perspective. We aim to analyze the hospital performance through collective action, while identifying several topics such as communication, information exchange and knowledge sharing.

This paper is organized as follows. Section 2 introduces the concept of collective action. Section 3 presents the methodological approaches outlines. In addition, a qualitative and experimental approach is applied. Section 4 presents the study results of patient experience. The last section concludes this paper and introduces some perspectives for future work.

2. THEORETICAL REVIEW

From 1960s, the social sciences disciplines, such as sociology, political and economic sciences, have been interested to the collective action. Moreover, organization, such as healthcare institution, refers to human environment in which many configurations of collective action exist. Crozier & Friedberg (1977, 1981) considered the action as collective which requires an organizational rules. Olson et al. (2011) defined the collective action as a social phenomenon. They considered collective action as a legitimate mode of participation. They found out that people are not able to engage easily in group works which do not suit their interests. This implies that people are confronted to many difficulties that affect their resources in terms of communication and collaboration.

On the other hand, Dolata & Schrape (2016) identified two basic types of social collective: non-organized collectives and collective actors (see Table 1). They considered that individuals contribute and collaborate with each other in a community way. These individuals organize activities in order to promote their interest. This improves social environment transformation, such as optimizing services and restructuring organizations. Finally, many studies proved that these transformations make difference in social reality.

<table>
<thead>
<tr>
<th></th>
<th>Non-organized collectives e.g. masses, swarms, crowds</th>
<th>Collective actors e.g. movements, communities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources for action</strong></td>
<td>Situational aggregation of individual resources</td>
<td>Collective resources contingent on the contributions of the participants</td>
</tr>
<tr>
<td><strong>Mode of decision-making</strong></td>
<td>No collective decision-making capacity</td>
<td>Strategic decisions dependent on the preferences of the participants</td>
</tr>
<tr>
<td><strong>Capacity for action</strong></td>
<td>No independent capability for intentional and strategic action</td>
<td>Capable of intentional and strategic action</td>
</tr>
<tr>
<td><strong>Activity pattern</strong></td>
<td>Collective behavior as aggregate of individual actions</td>
<td>Collective action on the basic of consensus, negotiation, voting</td>
</tr>
</tbody>
</table>

Table 1. Non-organized collectives & collective actors (Dolata & Schrape, 2016)
Lorino (1989) defined collective action as the group’s common action which seek to achieve certain goals. Collective action is a social practice that includes identity, culture and ideological issues. It provides the opportunity to manage social and organizational problems that affect people’s missions. In addition, several theories considered material conditions and focus on socio-psychological dimension of collective action. These conditions are recognize as causes of collective conflicts (Hovland & Sears, 1940).

Van Zomeren et al. (2008) proposed SIMCA (Social Identity Model of Collective Action) as a collective action model. This latter is considered as an integration perspective on collective action. SIMCA assumes that people tend to react to inconvenient. This model has become the most influential model of collective action (Langer et al., 2019). It is composed of three variables: social identity, injustice and efficacy. The social identity is the main actor of collective action. Social identity approach is the conceptual and psychological connection between injustice and efficacy reactions (Van Zomeren et al., 2008).

Furthermore, the group member allows to evaluate collective efficacy. This latter affects the individual’s decision and allows to engage in collective action. In fact, self-efficacy determines the individual’s behavior. Van Zomeren et al. (2012) proved that a collective reaction produces an evaluation of collective efficacy. Jost et al. (2017) added the variable of group-based anger to specify the effects of social identity on injustice and collective efficacy (see Figure 1).

Thomas et al. (2012) introduced the encapsulation model of social identity in collective action (EMSICA). They showed an alternative complementary role for social identity. Moreover, they deduced that an interaction took place between injustice and efficacy during a transformation project.

Recently, Langer et al. (2019) considered that socio-psychological models are an inherently ideological decision. These models exist in a societal context in which some people are motivated to defend an existing system, whereas others are motivated to challenge and resist the same system. Consequently, an explanation of socio-psychological model is required in order to establish a collective action. This explanation must include several processes such as interpersonal and intergroup processes.

![Figure 1. Social Identity Model of Collective Action (SIMCA, Van Zomeren et al. 2008). The variable of group-Based Anger added by Jost et al. (2017)](image-url)
Management is an essential science that develops and studies new collective action theories. The collective action based on restructuring project is considered as development theory. This theory must combine the designs and rules of actions (Bréchet & Desreumaux, 2008). This implies, the importance of collective action in organizational change. In this context, priorities are associated to individuals according to the collective projects.

Hatchuel (2005) focused on three mainly contributions: the modeling of prescribing relationships as the core of the organizing action, the modeling of post-decisional logic with C-K (Concept-Knowledge) theory, and the theorization of collective action. The Hatchuel’s collective action theory is principally characterized by knowledge and relationships. This theory is called “the knowledge/relationships axiomatic”. Hatchuel (2007) shows that “both markets and hierarchies are special and highly unstable forms of organization, because they imply that either knowledge or relationships are frozen”. Laufer et al. (2012) defined collective action as the result of inseparable and dependent dynamics between knowledge and relationships. In this paper, we mention the importance of the organizational change results.

Segrestin et al. (2017) defined the organizational change as conscious that modify an organization in accordance with some form of expertise and pre-established models. This change cannot be manage without learning processes. In fact, learning knowledge collectively and implementing managerial techniques are required. Hatchuel & Molet (1986) observed that the final state of change was itself a matter of learning. They considered the change as a way to engage a reflexive learning processes within the organization. In addition, Girin (1995, 2004) considered collective action as an organizational arrangement. It is the combination between humans, materials, and symbolic resources to improve the organization performance.

Collective action exist within several companies that are confronted to organizational changes. In particularly, healthcare institutions are confronted to several changes that need to optimize theirs services. For instance, the transition of the hospital model from a professionalized institution to a local healthcare space. Feroni (2006) assumed that this transition allows the hospital to achieve the change through managerial governance. This change refers to a collective action that aligns relationships, knowledge and resources between individuals and collectives. These latters develop the services, create a business models and respond to new technologies to fulfill their requirements. They create working groups, including one or more categories of professionals within the same organization. Collectives reconsider priorities, values and concepts (Olson et al., 2011). Therefore, connections between groups are strong in terms of community. It contributes to improve the quality of relationship between operational teams.

The following section introduce our empirical study which identify the patient experience within a healthcare institution.

3. EMPIRICAL VALIDATION

This section is dedicated to an experimental realism evaluation using multiple qualitative methods. This experiment began in 2017 till present day, it took place in a private French hospital which is confronted to a total reconstruction project. This hospital is a medical and surgical institution that includes a maternity and an emergency unit. It has a capacity of 305 beds, equipped with a high performing technical staff, operated by several medical and surgical specialties. The hospital is managed by 120 private practice doctors, and employs approximately 500 employees.
An audit was performed on the general structure of the hospital. The results showed a major deficit in patient reception compared to competing facilities. For this reason, a redesign for the institution has become a necessity to optimize all services. Managers identified the needs for their organization and adapted a business plan to improve patients’ satisfaction. They established a process while adapting new managerial practices in order to solve hospital issues. The restructuring of patient experience has become the primary objective of the hospital. This restructuring is considered as the main difficulties in the healthcare institution management. Furthermore, the hospital is also confronted to several challenges, such as connectivity and collaboration systems.

Due to the delay of the reconstruction project, we focused particularly on the entire patient experience. More precisely, we focused on the scheduled hospitalization from admission until discharge including patient registration, file preparation, and medical consultation. In fact, the hospital’s managers, administrators, and healthcare providers are all concerned by the patients’ hospital experience. We identified three main problems: structure of the building, patient waiting time, and the lack of communication and information. The following part presents the data collection. These latter are collected from different type of employees in order to discuss several expectations related to the patient experience optimization.

### 3.1. Data Collection

This study is based on an inductive approach (Glaser & Strauss, 1967) which is characterized by field observation. This approach is appropriate to understand the reality of healthcare institutions in a complex environment. In addition, it provide several explications and descriptions of collective action.

Data collection correspond to multiple forms of interviews, meeting participations, and field presence. These data are collected from various employees concerned by the patient experience. Therefore, we developed a framework for analyzing the hospital dynamics and its interaction between individuals. Data were collected as follows:

- **Semi-structured interviews:** 15 individuals have participated in patient experience development (see Table 2). These individuals are guided by interviews with managers, professionals, and personnel of the hospital. Three main subjects were discussed: work responsibilities, hospital reconstruction, and patient experience optimization. These interviews identified the institutional needs, such as an information system which can be adaptable to the individual’s requirements. Therefore, the implementation of new systems improves the patient’s relationship and develops team knowledge. In addition, management identified expectations in order to optimize the patient’s hospital experience.

- **Observations:** participative and non-participative observations of some events, such as board and staff meetings. These observations highlighted some evolutionary tasks for patient experience that explore interaction between individuals.

- **Documents:** a range of documents such as progress reports and newsletters were gathered in order to complement the collected data.

- **State of play:** an assessment was conducted in order to study the patient experience issues and challenges. Difficulties were identified related to patient experience coordination, absence of patient’s scheduled appointment, and lack of planned staff schedule.
<table>
<thead>
<tr>
<th>Function</th>
<th>Initial</th>
<th>Department</th>
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<tbody>
<tr>
<td>1 General Director</td>
<td>GD</td>
<td>Executive Directors</td>
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<tr>
<td>2 Assistant General Director</td>
<td>AGD</td>
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<td>3 Human Resources Director</td>
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<td>4 Healthcare Director</td>
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<td>5 Finance and Administrative Director</td>
<td>FAD</td>
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<tr>
<td>6 Technical Director</td>
<td>TD</td>
<td>Patient’s Experience Department</td>
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<tr>
<td>7 Admission Manager</td>
<td>AM</td>
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<td>8 Patient Relationship Manager</td>
<td>PRM</td>
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<tr>
<td>9 Patient Experience Personnel (1)</td>
<td>PEP (1)</td>
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<td>10 Patient Experience Personnel (2)</td>
<td>PEP (2)</td>
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<tr>
<td>11 Patient Experience Personnel (3)</td>
<td>PEP (3)</td>
<td></td>
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<tr>
<td>12 Patients Advocate (1)</td>
<td>PA (1)</td>
<td>Personnel Department</td>
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<tr>
<td>13 Patients Advocate (2)</td>
<td>PA (2)</td>
<td></td>
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<tr>
<td>14 Syndicate representative (1)</td>
<td>SR (1)</td>
<td></td>
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<tr>
<td>15 Syndicate representative (2)</td>
<td>SR (2)</td>
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Table 2. Semi-structured interviews of individuals participating to the patient experience development

4. RESULTS AND DISCUSSION

In order to evaluate the data collection, we initiated an analysis of documents, fields’ notes, and interview transcriptions. In this study, we defined three factors related to the dysfunction of patient experience: structural, organizational, and human relationship. These factors correspond to collective action context. Difficulties related to these factors were discussed with participants (see Table 3, 4 and 5).

4.1. Structural environment

Hospital’s setting is very critical for patient, personnel, and healthcare professionals. The hospital’s building was examined and several maintenance issues were found. The infrastructure is still functional and well maintained with a high investment cost. However, the dispersion of the hospital’s departments is mainly due to the old architecture of the building. This dispersion is considered as the main default of the overall patient experience. Once entering to the hospital, patients are confused due to the lack of directions. Consequently, the quality of services does not meet the expectations of the private hospital as well as its activity.

Participants argue that administrative and medical services need to be reorganized. They agreed that the reconstruction project allows to change the department’s location in order to satisfy the patient’s requirements. In fact, the institution structure is a reflection of the quality of hospital services. Participants describe the need for an innovative system, such as a centralized information system. As we mention previously, structural features influence communication, collaboration, and collective action implementation (see Table 3). Therefore, restructuring is the most common objective to reorganize the patient experience and improve the interaction between the institution and its patients.
We are confronted to several competing facilities. Our main objective is to improve the quality of service and to give the space for healthcare professionals. In addition, we aim to provide a global approach for patient experience (GD).

The hospital is confronted to several difficulties such as the old architecture of the building. It is very difficult to manage an old structure. These difficulties affect the staff feeling of belonging at different levels (HRD).

Today, our main difficulty is the absence of a common platform. The administrative and medical departments need to be reorganized. The patient experience is not guided. The patient is confused within the building and cannot follow easily his journey steps (PRM).

The problem is that we are managing the patient waiting time using unadaptable locations (AM).

The offices location must be designed according to the patient experience needs. It is a real problem to manage (PEP).

The healthcare professionals, especially practice doctors, are interested in the institution image and the innovation systems. These two factors impact the doctors’ integration into our organization (AM).

Our daily activities are defined by the daily problems of manager occupation in order to maintain the employee activities. Managers still can’t imagine our future institution (FAD).

Table 3. Structural environment difficulties

4.2. Organizational transformation

The obsolete building is one of the reasons for the institution’s transformation. Moreover, the digitalization of the hospital’s infrastructure is an opportunity to optimize the resource management and develop the organization’s capacity. This digitalization allows the remote connection while maintaining human interaction. In fact, human interaction is essential in a hospital environment. Therefore, digitalization improves the administrative organization function. It creates change and promotes patient education.

Participants identified the lack of equipment and information in various offices (see Table 4). For instance, the software platform for medical information system is not suitable, since patient information cannot be combined on the same platform. For these reasons, patient admission takes more time than usual. This makes the whole process more complex and tedious.

In this context, several conditions reduce the opportunity of collective interaction, communication, and teamwork. Individuals may have difficulties to engage in action and connectivity projects. The issue of treating information correctly is fundamental to collective action theory. The individuals must adapt to the organizational changes using various techniques and directions. Therefore, it is necessarily to study the progress of the collective action. In this study, we deduce that collective action will influence the evolution of hospital activity, such as the flow of patients. Participants argued that collective action cannot be achieved without individual and collective participation.

In addition, we observed that the admission and hospitalization processes are not meeting the patient’s expectations. The employees of patient experience are seeking to improve the
coordination’s tools, which includes the hospital’s manual. This latter is a mandatory tool which respond to the patients and healthcare provider’s needs. Therefore, the patient’s expectations can be reached only if the implementation of these tools are clearly identified and respected. For this reason, patient experience must be well managed and prepared. This is primarily related to the coordination between different departments. Finally, organizational performance is the institution capacity which satisfy the patient’s requirements, while preserving the best quality and using the shortest waiting time.

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I consider the hospital as an extremely complex institution. Therefore, managers seek to provide the employees with an excellent quality of work life (HRD).

Tomorrow, the patient experience must be guided. The institution have to take into consideration the digitalization requirements (HRD).

It is necessary to know how to manage the patient experience in a single day. The administrative procedure must be completed once the patient is admit (SR).

We have a lack of communication and information. Everyone must give the same information to its colleagues and patients. It’s about getting the right information (SR). For this reason, a better collaboration is needed between administrative and medical staffs (PEP).

We need an equipped office with an information systems. This allows a better communication between patients and colleagues (PEP).

**Table 4. Organizational transformation difficulties**

**4.3. Human relationship**

Human relationship is identified through existing functions between hospital and patient. This relationship is characterized by administrative and medical team’s interactions. These latters do not always fulfill the patient’s requirements. Hence, patient experience is more and more complex and it limits the flexibility of relationships. During the interviews, participants mentioned the importance of human relationship. This relationship allows the hospital to support the patient in expressing their needs and facilitate their access to healthcare services. Therefore, patients will communicate with professionals having direct contact with healthcare services.

Patient, family, and visitors need to be satisfied with all services offered by hospital. We identified that human relationship affect the quality of care, and patients are more interested in all hospital offers. In fact, the additional services are fundamental to the hospital’s financial and developmental capacity. Patients are able to communicate their needs more effectively, since they receive quality of relationship. Consequently, the human relationship will contribute to promote the hospital’s identity (see Table 5). This relationship will respond to the hospital’s requirements such as: resource optimization, managing patient flow, and developing financial capacities.
Patients expect to receive a clinical services and a specific human relationship since we are in a private organization (PRM).

More personal contact with patients is needed. Innovative platforms must be implemented to manage phone calls (PA).

The employees are confronted to many situations that impact the communication with patients negatively. We need to change our information system (TD).

The patient experience problem is human. More precisely, it is about human willingness (SR).

Table 5. Human relationship difficulties

| Strong human relationships are essential in healthcare institutions. They allow institutions to develop their organizational flow. The flow of patient process requires a specific coordination of patient care management. The staff rotation of operating rooms is increasingly tense due to the patient turn over. Therefore, the coordination of patient experience is essential in the flow of management. The patient’s history assessment needs to be completed in order to estimate the staffing demands. A relationship with patients is needed before and during their admission. Hence, the individualization of patient’s care should be confidentiality established in a system.  
Finally, we deduce that collective action is not a sum of operations, but a combination of a problems that needs to be resolved. In this paper, we argued that implementing collective action must be performed by developing communication opportunities. This is can be done by providing trainings and developing sense-making. Collective action develops common objectives, and achieves individual knowledge and skills.  
5. CONCLUSION AND PERSPECTIVES  
This paper presented the patient experience as a collective action within a private French hospital. The theoretical aspect studied several features of collective action in social and management sciences disciplines. In this paper, we proved that the coherence between knowledge and relationships, studied by Hatchuel, is essential to achieve collective action within an institution. In addition, we found out that implementing this action is fundamental. However, the collective action integration in a healthcare institutions projects is too hard, since involving the employees is complex.  
The empirical aspect of our study consists on providing observations and managerial expectations. Managers, professionals, and staff were considered as the main participants of our study. Based on the interviews, this study identified the difficulties of patient experience particularly in structural, organizational and human relationships issues. Therefore, we deduced that an alignment is required between these issues to achieve a perfect collective action.  
This study is limited in defining the different theoretical studies of collective action. Furthermore, this study is limited in examining collective action through particular aspect related to patient experience. It is also limited to the analysis of the participant’s recommendations and management expectations. The perspectives of our work are the following:  
- Focusing on operational aspect for collective action within the institution.  
- Studying the collective action which considers mainly the hospital’s reconstruction project. |
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