DEMOCRATIZATION OF THE BOARDS OF DIRECTORS OF ANGLOPHONE HOSPITALS IN QUEBEC

© JOAN EAKIN-HOFFMANN

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Department of Sociology
McGill University
Montreal, Quebec, Canada

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ABSTRACT

The thesis analyzes Quebec's effort to restructure hospital boards of directors in order to make them more representative of the community and of hospital personnel. The social organization and organizational functions of the former "elite" boards are examined and then used to analyze the process and outcomes of "democratization". The former elite membership retained considerable control over the new boards, although loss of internal social homogenity and interpersonal trust changed the nature of board work. A decline in overall board authority and a rise in "insider" representation affected the distribution of power between administrators, doctors and boards of directors. The persistence of the elite board model is discussed and is attributed primarily to its consistency with the class structure of society.

RESUME

La thèse présente une analyse des efforts du gouvernement québécois pour restructurer les conseils d'administration des hôpitaux afin de les rendre plus représentatifs de la collectivité et du personnel hospitalier. L'organisation et les fonctions des anciens conseils d'élite, ainsi que les relations personnelles entre leurs membres, sont examinées et par la suite utilisées pour analyser le processus et les résultats de la démocratisation. Les membres des anciens conseils d'élite continuèrent d'exercer une influence très forte sur les nouveaux conseils, même si une perte d'homogénéité et de confiance entre les membres a changé la nature du travail de ces conseils. Un déclin de l'autorité des conseils et une augmentation de la représentation du personnel hospitalier ont modifié la distribution du pouvoir entre les administrateurs, les conseils d'administration et les médecins. La persistance du modèle de conseil d'élite est discutée et est attribuée principalement à sa conhérence avec la structure de classe de la société.

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PART I

INTRODUCTION

The purpose of Part I is to identify the research problem and set it in historical and social context, and to outline the methods and materials used in the analysis. Chapter I describes the nature of the reorganization that took place in Quebec's hospitals sector in the early 1970's. Chapter II reviews the literature to specify the research issues and to get empirical and theoretical purchase on issues of democratization and hospital administration. Chapter III describes how data were acquired and used and discusses certain methodological problems and strategies.

CHAPTER I

BILL 65 AND THE DEMOCRATIZATION OF HOSPITAL BOARDS

In 1971 the National Assembly of the Province of Quebec enacted "Bill 65" a proposal for restructuring the province's health and social service system. A guiding principle of this legislation (Statutes of Quebec, 1971) was "participation," the involvement of the community in the administration and development of public institutions. In accordance with this law, the existing boards of directors of all health and social service institutions were dissolved and replaced by boards which were intended to be representative of the major social communities with which such organizations were associated--those who provide services, those who receive services, and a variety of others having some interest or investment in the establishment.

This dissertation attempts to describe and analyze aspects of this experiment in public participation as it occurred in the hospital sector, particularly in English-speaking or "anglophone" hospitals.[1] The purpose of this chapter is to sketch

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[1]Those hospitals with an easily distinguishable anglophone "character" which stems from a shared history of association with English-speaking Quebeckers. In the past these hospitals were founded, directed and funded by anglophones, had a primarily English-speaking medical staff, and were generally oriented towards the needs of the anglophone community. Despite the fact that these hospitals have recently been engaging increasing numbers of francophone doctors and serving a growing proportion of French-speaking patients, the English "character" of these institutions remains.

the social context in which Bill 65 was conceived and implemented. First, I look at the historical background and development of Quebec's hospitals and at the social characteristics of their administrations at the time immediately prior to the "democratization"[1] of their boards of directors by Bill 65. Then, I examine the concept of participation and its appearance in the social legislation of Quebec, and outline the nature of the board reorganization imposed on hospitals in 1971.

From Private Enterprise to Public Institution

In Europe in the Middle Ages, hospitals were in their institutional infancy. Oriented entirely towards the care of the poor and the dying, these organizations were primarily religious enterprises under monastic supervision. As ecclesiastical authorities became increasingly unable to cope with the growth of the system, the support and administration of hospitals passed to more secular authorities such as municipalities, local fraternities, and wealthy merchants (Rosen, 1963). This did not mean that hospitals became entirely secularized; the support of such institutions as hospitals remained an expression of Christian charity, the most effective route to salvation

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[1] A word not used in the legislation itself but which appeared frequently in the press and was used in public pronouncements of Ministry officials, such as in parliamentary debates. I use the word in this study to refer to the effort to render boards of directors more representative of and accessible to the general public than they have been historically.

and sanctification. In London in the middle of the 16th century, hospitals were administered by boards of governors comprised of "grave commoners, citizens and freemen" (Rosen, 1963: 16) who were responsible for raising the funds for the support of their hospitals. Throughout most of Europe, the hospital movement "found its impetus chiefly in private initiative and contributions" (Rosen, 1963:20), with governmental involvement limited to certain legislative actions. Indeed, the private founding and support of hospitals reflected in part the local government's inability and unwillingness to assume responsibility for the sick and poor. Thus, in the 18th and 19th centuries, a time in which they flourished, hospitals were private enterprises founded, administered and financially supported by prominent local laymen. However, they often exhibited vestiges of their ecclesiastical origins in the form of specific religious identities and religious staff.

Hospitals made their appearance in North America in the 18th and 19th centuries and assumed organizational structures and practices similar to European hospitals. A "frontier" and essentially "laisser-faire" social climate put additional pressure on individual communities and private citizens for the establishment and maintenance of such public institutions as hospitals.

In Quebec, both anglophone and francophone hospitals had roots in European traditions, but the latter did not undergo as much secularization as did many Anglo-Saxon institutions,

and remained under the control of the Catholic Church. Francophone hospitals tended to be founded by religious orders or, less frequently, by wealthy individuals, and administered and staffed by clerics and nuns. The ultimate direction of the hospital lay in the hands of a senior ecclesiastical authority of the sponsoring religious institution, who often supervised several hospitals. Anglophone hospitals, on the other hand, were mostly founded by wealthy local businessmen, entrepreneurs or community social "elite."[1] These hospitals were fashioned after business enterprises, being legally registered as "corporations" and directed by a board of directors representing the philanthropic equivalent of "shareholders," those financially supporting the organization.

Despite such administrative differences, however, French- and English-speaking hospitals were both essentially "private" enterprises, being founded, funded and governed by organizations or individuals largely outside governmental control. The private character of Quebec's hospitals, however, has been progressively modified since the second decade of the 20th century. In 1921, the Public Charities Act (Statutes of Quebec, 1921) marked the entry of the provincial government into the

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[1]Without getting involved in the very complex problems of definition that are actively debated in the literature, the "elite" referred to hereafter are people from the highest social strata in the community who are characterized by shared social acquaintances, common private school backgrounds and club memberships, high occupational status and, often, inherited wealth.

hospital sector. Public assistance institutions received financial help from the state for construction and development, and hospitalization costs of the indigent sick were shared equally by the province, the municipalities and the charitable institutions themselves. Since that time the financial involvement of government has gradually increased, culminating in the establishment of a hospital insurance plan in 1964 (Revised Statutes of Quebec, 1964a), and the introduction of "Medicare"[1] in 1970 (Statutes of Quebec, 1970). By 1971 essentially the entire operating budget of hospitals was provided by the State.

Administrative as opposed to financial control of hospitals, however, remained "private": internal organizational structure and institutional policy were left up to individual hospital authorities. Starting in 1963, however, with the Hospitals Act (Revised Statutes of Quebec, 1964b) the government made its first attempt at influencing the administrative structures of hospitals. This legislation required that, to qualify for financial support, hospitals had to be owned by a non-profit "corporation" and be run by a board of management that had at least one-third of its seats filled by individuals

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[1]The hospital insurance plan, by which hospitals were reimbursed by the government for the hospitalization costs of the entire population, was adopted in response to cost-sharing initiatives taken by the federal government. By 1961, all ten provinces had adopted such schemes. "Medicare", or universal health insurance, was also a response to federal cost-sharing incentives.

not employed by the hospital in any capacity and not more than one-third filled by in-house physicians. Hospitals lost the liberty to make policy concerning the "fundamental nature" of their operations (e.g. changing from a tuberculosis hospital to a general hospital) without consulting governmental authorities. The government was given the power to make regulations in such areas as the classification of hospitals, accounting and auditing practices, admissions and discharge of patients.

The administrative autonomy of individual hospitals was also increasingly limited by a plethora of external forces, for example, hospital accreditation agencies, professional organizations, provincial laws pertaining to building and labour codes and technological equipment, the university for which the hospitals were teaching facilities, other community service agencies to which hospitals were linked (e.g. chronic care institutions) and so on. Such environmental constraints illustrate the growing organizational complexity of the social arena in which hospitals operate, a trend frequently documented in the literature (e.g. Heydebrand, 1973; Arnold et al., 1971).

Despite the financial involvement of the government and the increasing environmental constraints with which hospitals had to comply, Quebec hospitals retained rather "private" administrative structures because the provisions of the Hospitals Act were only slowly and incompletely implemented. Requirements concerning the formation of a "corporation" and a board of management, for example, could be complied with on paper

while the hospital continued to be operated by much the same people and in much the same fashion as it always had.[1] Basic policy, such as that concerning fixed assets or the establishment of new services, remained the prerogative of individual hospital administrations. Their boards of directors, reflecting their historical origins, continued to be comprised of clergy, doctors, and local social elite in the case of francophone hospitals, and by the business, professional and social leaders of the community in the case of the anglophone hospitals. Table I indicates the composition of Quebec's hospital boards in the early 1970's before the reorganization under Bill 65. From these data, it can be seen that in 1972 Quebec's anglophone hospital boards were similar in composition to American ones. The data on French-speaking hospitals are consistent with the differences between anglophone and francophone hospitals mentioned earlier, notably their relatively greater number of clerics and doctors.[2]

In English-speaking hospitals, one notes that almost 75% of board members are from business, finance and related pro-

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[1] My own observation supported from private communication with an advisor to the Castonguay Commission (Commission of Inquiry on Health and Social Welfare, 1967-70) and with several hospital administrators.

[2] It must be noted, however, that the Quebec data for this table were obtained from a survey of hospitals in a large city. Most anglophone hospitals are found in this city because the English-speaking population is concentrated there, but the sample of francophone hospitals used is not necessarily representative of the majority of francophone hospitals.

TABLE I

United States and Quebec Hospital Boards: Percentage Distribution of Members by Occupational Classification

Occupational Classification	U.S. (Wentz, 1965)	U.S. (Goldberg et al., 1971)	U.S. (Berger, 1973)	U.S. (Kovner, 1974a)	Quebec French 1972[a]	Quebec English 1972[a]
Business and Finance	54.6	50.3	56.0	56.3	23.7	55.7
Non-health professions (lawyers, accountants engineers)	13.6	13.1	18.0	17.9	22.6	17.6
Physician	7.1	10.7	5.0	8.0	18.8	12.2
Middle management, Semi-professions (teachers, social workers)	3.5	4.0	7.0	3.2	12.9	4.1
Health professionals (excluding doctors)	X	2.3	X	X	.5	.7
Clergy	6.2	8.0	2.0	7.5	16.7	0.0
Housewife/volunteer	6.3	X	8.0	X	2.7	6.8
Blue Collar	2.3	X	X	X	0.0	0.0
Other	6.4	15.6	4.0	7.2	2.2	2.9

TABLE I

(continued)

Occupational Classification	U.S. (Wentz, 1965)	U.S. (Goldberg et al., 1971)	U.S. (Berger, 1973)	U.S. (Kovner, 1974[a])	Quebec French 1972[a]	Quebec English 1972[a]
Total	100	100	100	100	100	100
N	9,965	702	716	375	186	148
Number of institutions in sample	632	48	25	38	15	9

Notes: [a]Mail survey sent to 50% (N=20) francophone hospitals, randomly selected, and to all (N=11) anglophone hospitals, in Montreal.

[X]No data

fessions, particularly lawyers (in each of these surveys over half of the "non-health professions" category were lawyers). Notably, there are no individuals of the blue collar occupations and next to no health professionals other than doctors. The "housewife-volunteer" category refers almost exclusively to women of high social status in the community with careers as volunteers in social agencies (Ross, 1958, has described the volunteer as a career strategy for upper class women). Physicians comprised 12% of the board members, a figure somewhat higher than in the American surveys. The inclusion of physicians on boards of directors is a much-debated issue in hospital management,[1] generally because of the suspicion of "conflict of interest." In most of the hospitals in my sample, however, a representative of the medical staff has recently been included on the board in the interest, I was told, of "good communication."

Table I, then, shows that Quebec's anglophone hospital boards, like their American counterparts, were dominated by business and professional persons. More detailed analyses suggest further that many of these board members belong to the community's social and economic "elite." For example, in Goldberg et al.'s (1971) study, over 63% of their sample of board members were "business, financial and professional" persons,

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[1]The topic is raised repeatedly in the literature on hospital administration, see for example such journals as Hospital Topics, Hospital Administration, Trustee.

and of these 90% were executives, higher managerial personnel and business owners. Holloway et al. (1963), in an historical study of one hospital board, found that over a 50-year period "economic influentials"[1] comprised 53% of board positions, while the rest were "second level" executives.

Analyses of the specific occupational positions of board members in five Quebec hospitals (Table II) is suggestive of a similar "elite" character in my sample.

In hospitals A, B and C, three University teaching hospitals, about three-quarters of the board were economic or professional "elites" by this rough classification. On each of these boards, in addition, were several members of wealthy, "old" Quebec families whose names adorn commemoration plaques in hospital buildings and appear regularly on "life governor" and "patron" lists of other philanthropic enterprises around the community. The lower percentage of "elites" on the boards of hospitals D and E reflects the uneven distribution of leaders among different community organizations (as noted by Zald, 1967; Elling and Lee, 1965; Willie et al., 1963. See discussion in next chapter). Instead of top-level executives these two hospitals recruited presidents of smaller, local concerns or junior executives of larger companies.

In summary, then, at the time of Bill 65, Quebec's

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[1]The criteria used included size of property owned, top executive status in enterprises over a fixed asset value, overlapping directorates, number of employees.

TABLE II

Board Members of Five Anglophone Hospitals, 1972: Percentage Distribution by Occupational Distribution, Showing Predominance of Senior Executives

	Hospital				
	A	B	C	D	E
Presidents of national or international companies or banks	47	21	21	0	0
Presidents of local or smaller business concerns or financial houses	20	21	32	22	6
VP and Senior Executives	0	25	11	33	22
Senior partner professional (lawyer, C.A.)	7	4	11	1	11
Sub-total	74	71	75	56	39
Other occupations	26	29	25	44	61
Total	100	100	100	100	100
N	15	22	23	19	20

Source: Traced through hospital annual reports, business directories, and personal inquiries.

hospitals were under the financial control of the provincial government but they retained some autonomy over their own internal administrative structures. The composition of their boards of directors, while supposed to observe certain guidelines imposed by the Hospitals Act (Revised Statutes of Quebec, 1964b), were essentially determined by individual institutions. Analysis of the composition of these boards prior to reorganization showed that anglophone hospital boards were similar to their American counterparts--making it reasonable in the subsequent analysis to compare my data with American research--and were comprised primarily of men (only a small fraction of hospital board members were women) of high or "elite" social status.

Bill 65 and Public Participation

Although the notion of public participation in community or state institutions is not a new one, the 1960's witnessed a surge of interest in participation as an expression of democracy and as an antidote to social unrest, alienation, and bureaucratic unresponsiveness. In the United States, for example, consumer participation became a key ideological component of much socialpolicy, including the anti-poverty programs of the Office of Economic Opportunity, and "grass-root" involvement became a prerequisite for many government-financed projects. The industrial sector was also marked by widespread interest

and experimentation in participatory management, particularly in Germany, Norway, and Great Britain. These and all such programs that espoused principles of democratic decision-making were founded on the idea that it is intrinsically good for people to have access to and be able to participate in the decisions of the institutions that affect their lives. Public participation was also considered "good" for institutions: it was expected to energize them and make them more responsive to user or employee needs and preferences.

In 1964 the Canadian government published the report of the Hall Commission (Royal Commission on Health Services, 1964) which reviewed the existing medical care scene in Canada and pointed out deficiencies in services, manpower, funding mechanisms and so on. The report recommended a universal health insurance plan and other changes to the system but made no mention of public participation in the development or administration of health services. Indeed, the report took pains not to frighten the medical profession.

> . . . our recommendation relating to the manner in which health services should be organized recognize the *paramount position of the personnel* providing health services. They *do not involve any control over the physician-dentist in the practice of his calling.* (Chapter 7, Book II, page 199. Emphasis mine)

Although participation did not appear to be of much concern to the members of this federal Commission, it was beginning to appear in the social policies being formulated in

Quebec. The 1960's were the years of Quebec's so-called "Quiet Revolution," a time in which the province was undergoing rapid transformation from a rural, church-dominated society to a secular, urban and industrialized one. The State was in the process of replacing the Catholic Church as the new political and social presence in Quebec, a process that involved fundamental reform of the province's major public institutions. Education was one of the first social responsibilities formally appropriated from the church and reorganized. The first section of the report of the Parent Commission (Royal Commission of Inquiry on Education, 1963-1966) stressed public participation in its proposed new education system.

Interest in public participation was also reflected in the next major social reform study in the province, that carried out in the health and social welfare field by the Castonguay-Nepveu Commission (Commission of Inquiry on Health and Social Welfare, 1967-1970). Appointed in 1966 and completing its work in 1970, the Commission held public hearings for two years and conducted extensive visits to other countries. The major thrust of its health proposals was towards the regionalization and decentralization of services. Particular emphasis was placed on participation of the public throughout the proposed health system. Indeed, one of the "guiding principles" of the "Health Plan," as it was called, was:

> . . . the decisional and advisory participation of the people served by the plan's bodies so as to

> facilitate constant adaptation of the plan to the changing needs of the people. (Volume IV, Tome II, p. 91)

Among other provisions for citizen participation, the Health Plan suggested that hospitals were to be administered by "corporations" acting as boards of directors which would represent such constituencies as the people in the catchment area, health professionals, regional planning offices, local health clinics and the affiliated university.

In 1970, Mr. Claude Castonguay, chief architect of the Commission's report, became Minister of Social Affairs in Quebec, which put him in an ideal position to implement the study's recommendations. Bill 65, the first major legislative sequel to the Commission, was given first reading the following year. A number of changes were introduced in the organization of health services, such as policy for the development of local health clinics, the restructuring of professional bodies in hospitals, new institutional classifications, patient rights and the administrative regulation of corporate structure. Many of the main proposals of the Castonguay/Nepveu report, however, were diluted in the proposed legislation. For example, the three semi-autonomous regions envisaged in the Commission's Health Plan were replaced in Bill 65 by twelve relatively powerless ones. Public participation, however, survived the legislative process and was incorporated into the proposed law. The principal strategy for implementing this participation was

the reorganization of the administrative structures of all health and social welfare institutions. Hospitals were to be legally incorporated and the land, buildings, and other physical facilities that comprised them were to be owned and directed by "corporations" with their own boards of directors. Distinct from the Corporation, however, was the "Hospital Centre" which included the operation of the hospital itself, the distribution of care, the organization of personnel and so on. Each Hospital Centre was also to be run by a board of directors, and it was into this board that the law injected the notion of participation and representation. Previously, of course, the hospital "corporation" and running the hospital had been synonymous and there was only the one board of directors). The board of directors of a "hospital centre" had to be comprised as indicated in Table III. The hospital's administrator was to sit on the board in an advisory capacity only. The term of office was 1 year, except for the 8 members who represented the patients, the "socio-economic groups" and the hospital's Corporation, who were to have two-year terms.

Given that this legislation affected 1,500 institutions and all those who worked in them, it is not surprising that more than 100 briefs were presented to the parliamentary hearings on the Bill by individuals, groups and organizations. Considerable concern was expressed in these briefs over the democratization of hospital and other boards of directors. Professional groups, for example, felt they were under-represented

TABLE III

Required Membership of the Board of Directors of a Hospital Centre and the Mode of Selection, According to Bill 65

Number of Members	Representative of	How to be Selected
2	Users or patients of the hospital	Elected at a meeting of these constituents.
2	Major socio-economic groups in the community	Candidates proposed by local civic, business service or other organizations. Final appointments made by the government
4	The hospital "Corporation" comprised of financial benefactors	Elected by these constituents at their annual meeting.
1	Professionals in the hospital, including nurses, social workers, physiotherapists, etc.	Elected at a meeting of these constituents.
1	Physicians and dentists in the hospitals	Elected at a meeting of these constitutents.
1	The hospital's non-professional staff, including administrative personnel, maintenance and kitchen staff, orderlies, etc.	Elected at a meeting of these constituents.
1	Local community health clinics with referral contract with the hospital	Appointed by the board of this clinic or jointly with boards of other affiliated clinics.
1	University (if the hospital is a teaching unit)	Appointed by the board of the University
1	Interns and residents in the hospital (if a teaching hospital)	Elected at a meeting of these constituents.

in the management of health institutions and many felt very threatened by the spectre of "community control." Others felt the former volunteer trustee system was too valuable to damage and feared that the new boards would become the stage for "trouble-makers" and self-interested or politically motivated activists. The presentation made between readings did not produce any major change in the legislation concerning the composition of boards, but they did testify to the salience of this aspect of reorganization for many involved in the hospital enterprise.

Bill 65, then, reflected the government's interest in both consumer representation (the patient and "socio-economic group" members) and employee participation (the professionals and blue collars workers in the hospitals) and its desire to institutionalize communication between hospitals and other agencies in the health sector (the community clinics and the University). It is important to note at this point, however, that the legislation was aimed at all Quebec hospitals. The English-speaking hospitals with which this study was chiefly concerned comprised only a small proportion of the total hospital sector. This meant that reorganization was predominantly aimed at the average French-speaking hospital dominated administratively by religious orders and/or doctors. That is, the law was not designed with the anglophone business-professional board in mind. Nonetheless, both anglophone and francophone hospital boards represented only a very restricted range of social interests

and it was principally this lack of broad public input that the government wished to change.

CHAPTER II

THE LITERATURE AND THE RESEARCH PROBLEM

In the previous chapter I briefly described the social context in which hospital board reorganization took place in Quebec. Before Bill 65, these boards of directors were mainly comprised of ecclesiastical authorities and doctors in the case of French-speaking hospitals, and of businessmen and professionals, in the case of anglophone hospitals. In 1973, legislation was passed under which these boards were dissolved and replaced by a specified structure that was intended to broaden the representativeness of their membership.

This chapter reviews three areas of research in the literature that give perspective on the process of board reorganization. First, is the research on democracy and participative decision-making in organizations. Second, is the analysis of power and control within hospitals. And third, is the study of boards of directors as organizational sub-units.

Democracy in Institutional Decision-making

Although issues of democracy have been debated for centuries, it is in the last twenty years that "public participation", "community control", and "lay involvement" have become catchwords in much public policy and that the concept of

"participation" has been incorporated into planned social change. Particularly, attempts have been made to bring traditionally disenfranchised groups--such as the poor, minority groups, consumers, non-management employees and so on--into processes of organizational decision-making. "Participation" has been introduced into a wide variety of organizational settings, such as schools, welfare and health agencies, policy planning bodies, as well as in business and industrial enterprises. The literature attempting to assess the results of these participation schemes is vast. Although most evaluation is rhetorical (as I discuss shortly), the research that *is* analytical presents, with few exceptions, consistent findings (see Cunningham, 1972, for detailed review). In general, investigators have found that public participation on policy and planning boards, advisory councils and the like, seldom resulted in better--or even different--services. The poor or otherwise disadvantaged population acquired very little influence over decision-making, and organizational control remained largely in the hands of professionals, agency officials or community elites. Where a certain participation was achieved it often consisted of only upper-stratum poor, or of minority group activists who used the programs to further specific ethnic group interests. The introduction of new constituencies and interest groups, moreover, generated conflict and antagonism and often led to the loss of financial support by funding agencies or in the suppression of public input by higher

authorities (Marris and Rein, 1967).

In the health sector, citizen participation has been injected into municipal hospital administration, consumer health advisory committees, community mental health centers, health planning agencies, prepaid health plans, and, particularly in the United States, into Neighbourhood Health Centers. The experience has been much the same as in other public services, although participation in medical services has been additionally hindered by such factors as the episodic nature of consumer use of health facilities, the power and prestige of health care providers, and the absence of role models for lay involvement in decisions which are perceived to be too scientific or technical for non-professionals (Stoller, 1972; Bellin et al., 1972; Mogulof, 1970). Furthermore, health institutions are generally not perceived as responsible for individuals' health problems and health care is seen as an individual concern rather than as a community problem (Lipsky and Lounds, 1976). Additional problems associated with identifying and mobilizing a "constituency" in the health sector are widely acknowledged. For example, many "users" are unable to participate precisely because they are unwell or infirm.

To my mind, however, much of the literature on participation is myopic and unenlightening. Its principal weakness is its pervasive normative bias and the limited perspective such a posture imposes on the analysis. By "normative bias" I mean that ideological assumptions influence the research endeavour,

that certain ideas about the nature and consequences of participation effect the way problems are conceptualized and formulated. For example, many studies try to assess the *outcome* of participation. Researchers however, have pre-conceived ideas about what democratic decision-making *ought* to do, hence they choose their "outcome" or dependent variables on the basis of these beliefs. Thus, because investigators believe that participation ought to increase user satisfaction, or make decisions more consumer-oriented, or make the organization more responsive--or whatever--they look for these particular outcomes. When no change is found on these dimensions, the conclusion is often made that "participation" had no effect, when it is entirely possible that change has occurred in other unexplored areas. Change is overlooked because it is unintended. Ideological beliefs pre-determine what the researcher is looking for rather than theory being "grounded" (Glaser and Strauss, 1967) in the empirical social situation. Other researchers are more concerned with *process* than outcome, often because they tend to view participation as an end in itself rather than as a means to an end. They ask what change has occurred in how decisions are made, or how much new participants actually contribute. Participation, however, is often measured against some unknown or absolute vision of democracy, ignoring what we already know about the nature of group decision-making from such fields as social psychology and the sociology of organizations.

A restricted range and depth of investigation stems from other attributes of the literature besides normative bias. For example, studies often fail to employ change as a relative concept, and attempt to assess the impact of participation without an appreciation for what went on before. The prior social scene is usually only briefly described, without empirical examination, and is often stereotyped (e.g. decision-making power is attributed without verification to certain obvious persons or groups, such as professionals, administrators, or boards of directors).

A related point is the literature's general tendency to concentrate entirely on the perspective of the newcomers, those striving for power and involvement, to the exclusion of those who must relinquish control. "Managers", "professionals", the "status quo" are often stereotyped concepts with no empirical flesh. A full understanding of the processes of power and change are assuredly not possible without a consideration of the perspectives and behaviour of those individuals or social groups already in positions of power.

A further important limitation of much of this literature is the conceptualization of participation issues in terms of the individual participants rather than in terms of broader social factors. Thus "failed" participation schemes are often interpreted as resulting from the personal inadequacies of the newcomers (lack of training, experience) or from the power appetites of incumbent policy makers (unwilling to surrender

influence). In contrast, few studies relate the outcome of participation to extra-individual factors such as:

- organizational structure: Michels' theory of the "iron law of oligarchy" (1949) maintains that organizational imperatives preclude the possibility of democratic leadership and create the social conditions that generate oligarchy.
- group social structure: Lipset et al.'s (1956) study of the International Typographical Union suggests that the oligarchic tendencies of organizations can be counteracted in favourable historical circumstances by social structures that promote active membership involvement and turnover in leadership.
- the general economic and class structure of society: Marxist analysis suggests that grass roots or worker participation in decision-making is doomed to failure because it cannot overcome basic conflicts of interest arising out of the political structure of society in general.

Analysis of the literature on participation and democracy in institutional decision-making, then, suggests a number of ways in which I might improve the fundamental research approach. First, normative bias must be reduced by ceasing to view issues of participation in terms of "success" or "failure" and by putting aside preconceived ideas of what happens in a participative

decision-making setting. Events and behaviour have to be understood in relation to their precedents, not in isolation. Analysis must encompass a broad range of perspectives, the perceptions of those holding power as well as of those seeking power. Finally, the analysis must also attempt to see participation not as a closed system but as contingent upon broader social structures.

Hospital Power Structure

If participation and board reorganization are to be viewed in broader perspective, the social organization of the hospital is of obvious relevance. The literature in this area offers a consistent, empirically-based description of the organizational structure and distribution of power within hospitals (e.g. Georgopoulos, 1972; Arnold et al., 1971; Moss et al., 1966; Wilson, 1963; Gordon, 1961, 1962; Viguers, 1961; Burling et al., 1956; Brown, 1949) which might be summarized as follows. The hospital is a highly stratified organization with layer upon layer of occupational categories in hierarchical order from the lowest maintenance worker through the nursing auxillary and technical staff up to the physicians. Few mobility routes link these strata, largely because of extreme technical differentiation and professional and union occupational restrictions. There are two hierarchies within this structure, the administrative and the clinical, in both of which

power is heavily concentrated at the top.

The administrative hierarchy includes all those involved in the non-clinical operation of the hospital such as housekeeping, laboratories and other organizational services, business administration and so on. Most of the authority in this hierarchy is vested in the general manager, or "administrator" because of his bureaucratic position, his organizational expertise (full-time contact with the hospital's operations and often, specialized training in hospital administration) and his "view of the whole" which those beneath him are assumed to lack because of their specialization.

The clinical hierarchy refers to the range of medical care professionals clustered around and controlled by the physicians whose authority is maintained in part by their technical expertise and the acquired dominant professional status which is premised on this expertise (Freidson, 1972). Within this hierarchy power is further concentrated in the senior staff physicians and department heads.

A third locus of authority in hospitals is the board of directors which is constitutionally responsible for the hospital and on which, certainly in the past, hospitals have been dependent for financial support. Most board activities tend to be directed by a small executive group or committee.

Power in hospitals, then, is heavily concentrated in the hands of the chief administrator, the senior physicians and the board executive, the familiar "administrative triangle".

Control of decision-making, however, is not equally distributed between these three groups. Boards, by virtue of their peripheral location and volunteer lay composition, are not usually involved in day-to-day operations because board members do not have the time and most often do not perceive themselves as competent to be involved in technological or professional matters (Kovner, 1974a, 1974b; Harkness et al., 1963; Price, 1963). The boards' distance from daily management and their inability or unwillingness to make decisions directly related to medical care, the hospitals' main "output", naturally restricts their organizational significance.

Administrators, in turn, despite their bureaucratic position and superior organizational knowledge, have their influence limited by the ultimate legal authority of the board of directors and, most importantly, by their lack of organizational control over the medical staff. Perhaps the single most unique organizational characteristic of the hospital compared with business and other institutional forms is the relationship of the doctors to the hospital. The individual doctor is paid for his services not by the hospital, but by contractual arrangement with his client, or a third-party such as government or an insurance company. In teaching hospitals, many physicians are on a number of payrolls, including the University and research funding agencies. Physicians, however, make the clinical decisions, which of course are carried out by hospital employees over whom they have no "line" administrative

control. At the same time, what exactly constitutes clinical versus administrative jurisdictions has never been clearly defined. What this means is that the board and the administrator have little formal authority over the doctors, with the exception of their ability to influence appointments and reappointments, an ultimate power that appears seldom to be used. The literature makes frequent reference to the difficulties hospital administrations have in exerting control over their doctors, and several empirical investigations found that the relationship of the physicians to the hospital and the associated problems of organizational control are the most difficult aspects of hospital administration for boards and administrators (Moss, 1966; Wilson, 1963; Gordon, 1961, 1962).

What, however, determines the distribution of influence within the board-administrator-doctor triangle? Why are some hospitals "run" by the doctors, others characterized by a "strong" board, while others are firmly under the control of the administrator? Several factors are mentioned in the literature, including personality,[1] and the professional competence of the administrator (White, 1971). In my view, however, the most important determinants lie in the hospitals' extra-organizational context, in their broader social environment.

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[1]Work by Elling (1963), Moss et al. (1966) and Perrow (1963) point to the role of individual personalities in hospital politics; in my research, several hospitals had, at one time, been subject to the strong personal influence of individual administrators, board members or doctors.

In Quebec, for example, any consideration of the distribution of hospital power must include the involvement of the provincial government in hospital affairs. With its assumption of financial responsibility, the government has also claimed the right more closely to supervise the administration and development of hospitals and has come to be directly involved in the whole range of hospital policy. For example, no major capital development, change in basic function, or even budgetary change can be effected without the prior approval of the Ministry of Social Affairs. Such supervision, of course, puts severe limits on the power of any one individual or group within the hospital. Other external sources of control also restrict the autonomy of internal hospital groups. Universities, for example, exert considerable influence over hospitals, from medical staff appointments to clinical organization, and such agencies as the hospital accreditation board or the hospital insurance board impose further restrictions and requirements. Other health institutions also influence hospital decision-making; for example, chronic care facilities, by virtue of their shortage are able to dictate many aspects of hospital discharge policy.

In more specific terms Perrow's (1963) case study suggests that hospital leadership shifts in response to such extra-organizational factors as technology and community need. In the early days of hospitals, proposes the author, construction and capital financing were the most critical organizational

problems, hence the domination of the board of trustees in the management of hospitals. Then, however, science and medical practice began to improve and treatment became more complex and specialized. Technology and research became the primary concern of hospitals, and the physicians' status rose accordingly. The physician's skill and knowledge became the basis for the eclipsing of hospital trustees in hospital power structure. Subsequently, however, the size and complexity of hospitals as organizations began to increase. Internal administrative problems multiplied and hospitals needed increasingly to relate to other community institutions. Skills other than those of the trustees or of medical staff were needed and the era of professional administrators began. Managerial expertise was not the only factor behind the rise in organizational importance of hospital administrators; the power of the medical staff also decreased as a consequence of professional fragmentation from specialization and the physicians' increased dependence on the hospital for technical services.

Perrow's analysis illustrates the relationship between the distribution of power within hospitals and broader social phenomena. The rise in power of the medical staff, for example, was closely related to the rise of medicine as a dominant profession in western societies and to technological development (Freidson, 1972). The relative power of administrators similarly reflected external professional and class differentiation. "Public" institutions such as hospitals have enjoyed

lower organizational prestige than "private" or other profit-making enterprises, and have offered less remuneration, both of which possibly contributed to the generally less capable administrators that hospitals were able to recruit in the past (Weaver, 1975). Moreover, until fairly recently, most administrators had limited or no specialized training in health administration, which, in an institution ordered on the basis of technical expertise, limited their ability to claim organizational power (Kovner, 1972). Social class distance between administrators and their boards or their medical staff further restricted the organizational power of administrators (Weaver, 1975; Perrow, 1963). The emergence of hospital administration as a major locus of decision-making power is thus related to the evolution of hospital administration as a professional specialty, to the development of a managerial technology, and to growth in the economic significance of the hospital enterprise.

In summary, then, the literature on the power structure of hospitals makes three contributions to my analysis. First, it suggests that power is key to understanding how hospitals operate. As Gordon (1962:72) concludes:

> The elements that are different in the voluntary hospital organization . . . stem from the power relationship, the control relationship and the alternatives available to each group in what can here be seen as a negotiated relationship. . . .

It is clear from the literature that the distribution of power

between administrators, boards and physicians is determined not by legal or bureaucratic considerations but *political process*, by interpersonal *negotiation*.

A second important suggestion from the literature is that this negotiation is influenced by social factors external to the organization, by features of the broader social structure.

Thirdly, it is noteworthy that hospital administrators have come to assume key organizational positions within the hospital largely through their ability to manage the medical staff.

Study of this literature directed me to the question of how the democratization of hospital boards influenced the distribution of power within the leadership triangle and what part external social structures played in this change.

Boards of Directors

A large number of organizations--industrial, social, public service and others--are constitutionally supervised by a board of directors. Very little is known, however, about this organizational entity partly because such concerns have been unfashionable in a discipline oriented towards the study of society's underdogs, the poor, or the bizarre, and partly because of problems of access to such social phenomena. Boards of directors meetings are typically closed to non-members, proceedings are kept confidential, and like other high-level

decision-making processes, are conducted more outside the boardroom than within it. Much of the literature is plainly rhetorical, expounding on what boards of directors *ought* to do rather than investigating empirically what they actually do.

Two general approaches to boards of directors are taken in the analytical literature. First, researchers have examined the composition of boards: what are the social characteristics of their members? Secondly, researchers have been concerned with the organizational significance of boards: What is their function within the organization?

Composition

"Composition" studies are concerned with the social attributes of board members, particularly occupational status, and with how these attributes vary between different institutions. Boards of directors, of major industrial corporations, are dominated by the leaders of political, financial and public enterprises (Navarro, 1976b; Mace, 1971; Vance, 1964). The composition of boards of social welfare and other public service institutions has not been documented as much as it has in business and industrial enterprises. However, as reported in Table I (page 9), studies in the health sector consistently show that board members are drawn from among the community's upper occupational strata. Between 60 and 85% of samples of hospital trustees in the United States of America have been found to be business, financial or professional persons, of

whom a very high percentage are senior executives and lawyers.

Several studies have noted a shift in the composition of boards over time. As Gordon (1962:68) observes:

> In recent years in many hospitals, the complexities of hospital administration have led to the selection of a relatively new type of trustee. Gradually replacing the 'blue chip' family social-elite type is the successful businessman, the professional public relations man, the financial expert, the lawyer, the engineer, and the expert in other fields that represent problems for hospitals.

Such movement from traditional social elite to the professional-managerial expert has been observed in corporate boards of directors (Kelner, 1970; Vance, 1968), in boards of philanthropic and public service organizations (Pfeffer, 1973; Willie et al., 1963-64; Harkness et al., 1963; Seeley, 1957; Ross, 1953) and in hospital boards (Hixson, 1965; Elling, 1963; Gordon, 1961). Holloway et al. (1963) however, found no decline in the participation of "economic influentials"in a hospital board over a fifty-year period. The social significance of such a "shift", however, remains unclear. Certain studies have reported that leaders themselves not directly involved in community organizations retain considerable control through the use of substitutes, or "leg-men" (Presthus, 1964; Hunter, 1953).

Another observation that is made in the "composition" literature is that boards are socially differentiated and stratified. That is, different categories of community leaders (e.g. Elling and Lee, 1966, distinguish "economic", "elected", and "knowledge specialties") tend to associate with different kinds

of community institutions. Financial leaders, for example, were found to be more heavily concentrated in coordinating agencies than in planning councils (Elling and Lee, 1966). In a study of community chests and councils, Willie et al. (1963-64) found that senior business and professional executives dominated the chests (financial decision-making) while managers and administrators sat on the Councils (planning of servives). Further data of Elling and Halebsky (1961), of Babchuk et al. (1960), and of Zald (1967), indicate that elites are distributed among hospitals parallel to their outside social statuses, with the more prestigeous individuals sitting on the boards of the more prestigeous hospitals. Prestige congruence is also maintained *within* individual boards: Holloway et al. (1963) found evidence of "economic influentials" assuming internal leadership within boards by dominating interaction at meetings and by monopolizing executive positions and committee chairmanships.

In sum, from the composition studies we learn that the boards of directors of social welfare and other community organizations are comprised of the community's business and social leaders who are distributed in patterned ways among these institutions.

Function

A second approach to the study of boards has been through the examination of how boards operate and what organizational

functions they perform.

There is, in general, a paucity of information on what boards actually do. Some attempts have been made to analyze the decision-making activity of boards (Partridge, 1973; Le Rocker and Howard, 1960) but the results of these efforts are not very meaningful because the source of data is usually meeting minutes (of dubious value because of recording inadequacies and the absence of the important informal decision-making that goes on outside the board room) and because the classification of "decisions" (e.g. "financial", "personnel" matters) is rarely tied to any theory or research hypotheses.

Another group of studies is concerned with the more theoretical issue of function. Several researchers maintain that the board's chief function is to link the organization with its environment, to "mediate" with other organizations and the public (Pfeffer, 1973; Zald, 1969; Harkness et al., 1963; Price, 1963; Parsons, 1951). Many studies point to the importance of the board in securing such external resources as money and public support (Pfeffer, 1973; Zald, 1969; Elling and Halebsky, 1961), while others describe how boards "represent" the organization to the outside world, and confer democratic legitimacy on institutional decision-making.

Notably, emphasis is on the *external* functions of boards of directors, on their links with the outside environment. Less attention has been directed to the boards' *internal* significance. A few studies make brief and unelaborated reference

to the managerial "control" functions of boards (Pfeffer, 1973; Zald, 1969), while many suggest that boards generally do not seek active participation in internal organizational affairs (Moss et al., 1966; Harkness et al., 1963; Price, 1963). Boards of hospitals are even less likely to be involved in internal organizational matters because, as Harkness et al. (1963) and Kovner (1974) report, board members do not feel qualified to judge medical care.

One serious problem with much of this research, however, lies in the assumptions made about the power of boards of directors. In many studies the researchers take for granted that boards are intrinsically powerful organizational units, that they are the locus of decision-making and control within the organization. A typical example of this tendency is the following observation in Babchuk's study of participation in community agencies (emphasis mine):

> *Since the board of the hospital has control over it,* the board members exercise vital power in the community . . . . (Babchuk et al., 1960:400)

The conventional wisdom is that boards are concerned with overall financial management and long-range planning. Galbraith (1967), however, suggests that boards of directors make only the most "routine and derivative" of decisions, and attributes belief in their power to corporate ritual. From a series of in-depth interviews with top-level executives of large American companies, Mace (1971) provides empirical support for

Galbraith's claims and suggests that the influence of boards of directors in corporate policy-making and in the supervision of senior executives is a "myth". The boards Mace studied did not ask discerning questions, or set policy; instead, they gave advice to the chief executive on special problems, exerted a mild disciplinary presence over the executive, and acted in times of organizational crisis. Vance's (1964) study of major U.S. corporations found that outside directorates (boards made up of individuals from other industries) abdicated effective control to the president in part because they lacked the time, competence and interest to get involved in operational detail.

Zald (1969) also views the issue of board power as problematical. In a theoretical paper he analyzes power as a function of the "resources" of board members (knowledge, access to community funds and support), their personal characteristics (age, sex, socio-economic status), and of "strategic contingency situations" (crisis, times of succession). Zald's distinction between "detachable" and "non-detachable" resources (knowledge and access to resources versus social status) appears inaccurate to me because the two are inter-related. For example, one reason why high social class is a source of power is because it *implies* a certain resource structure.

Other researchers view board power as a function of organizational need (Perrow, 1963; Viguers, 1961). Those groups or individuals who perform the most critical organizational tasks hold positions of greatest power. In his historical

analysis mentioned earlier, Perrow sees organizational and technological "needs" as determinants of the distribution of power in the hospital. The board was powerful relative to the doctors and the administrator when the hospital's principle "need" was financial support and community legitimation.

Elite Membership

The "composition" and "function" analyses of boards are, however, closely linked by one particular characteristic of boards: the social class of members. Such functions as securing resources and community legitimation are seen in the literature as dependent upon the high social status of board members. Indeed, numerous studies actually suggest that an elite board ensures superior organizational performance. Because of their high social standing, board members are better able to perform certain tasks that are key to organizational prosperity. In a study of leadership, Presthus (1964:413) found that those hospitals that had "institutionalized connections" with the community leadership structure through their boards, operated at a "higher level of competence". Belknap and Steinle (1963), in a comparative study of community hospitals, found that differences in quality stemmed directly from the way in which the hospital was defined by the social leaders of the community. The "best" hospital had the highest concentration of community elite on its board of directors. Zald (1967), in a study of the YMCA, found that the composition of boards was related to

organizational effectiveness: the higher the status of board members the higher the quality of organizational programs. Pfeffer (1973) found that hospitals whose board members were selected on the basis of their political and resource-getting capabilities, were more "effective" as measured by institutional growth.[1]

The association between organizational "success" and the social status of board members is generally explained in two ways. First, is the matter of solvency. The most obvious and frequently mentioned function of boards of directors is financial control and support. The boards of corporations have been found to "stabilize" the economic environment. For example, by including a "bank man" on their boards, organizations may improve their borrowing capacity and otherwise contribute to their financial security (Domhoff, 1971). In health institutions, a major job of trustees has been financial support. Zald (1967) found that the percentage of YMCA boards comprised of business leaders was positively correlated with the voluntary public contributions the organizations could secure. Elite board members were able to ensure support because they were often wealthy themselves and had the social connections to tap other wealthy people for donations. Trustees solicited

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[1]To my mind, growth is a very limited indicator of organizational effectiveness and is certainly inappropriate within the current context of financial crisis in the hospital sector, budgetary cutbacks, and curtailment of further expansion of facilities.

contributions by capitalizing on friendship obligations, often knowing that sooner or later the donor would approach him on behalf of *his* pet philanthropy (Blishen, 1950). Board members were also instrumental in securing support by virtue of their social reputation, as is illustrated in this observation from a contributor in Andrews (1953:29) study of attitudes towards giving:

> I rely on the names of the Board. If they are solid citizens, who are not interested in anything that isn't good, I sometimes give. . . . You don't want to give to an organization if you don't know what it is for or who's running it.

Ross (1953) also found that individuals donated to fund-raising campaigns on the strength of the canvasser's or campaign organizer's social attributes, reasoning that socially prominent citizens would not be associated with any undertaking that was not reputable. Even where allocation of financial resources was controlled by a central funding agency, Auerbach (1961) found that hospitals associated with prestigeous citizens still tended to receive more money.

A second explanation for the apparent organizational "value" of elite boards is that they are better able to secure *non-financial support* from the community. Public esteem and cooperation from other institutions and regulatory agencies, for example, have been cited as important organizational contingencies that a high social class board is well-equipped to influence. In-depth research and case studies such as Elling

(1963), Moss et al. (1966), Mace (1971), Belknap and Steinle (1963), illustrate the use to which elite board members can put their outside social connections. However, in a study specifically directed towards measuring the effect of an elite board on "community support", Blankenship and Elling (1971), found that financial support was the only significant index of "support" accruing to elite boards. Public preference, the supply of steady workers and number of volunteers associated with the hospital did not seem to depend on the social prestige of the board of directors. This study did not, however, use any indices of "community support" that tapped the hospitals' relationships with other organizations or government bureaucracies.

In summary, the literature relating to boards of directors indicates that boards of community organizations such as hospitals are primarily comprised of business and social leaders and that the board's function within the organization is closely related to the social status of their memberships. Studies, however, stress the external functions of boards of directors and pay little attention to their internal organizational significance. There is also a tendency to focus on the explicit functions of elite boards to the exclusion of possible indirect or latent ones.

The Research Problem

My approach to the issue of the democratization of Quebec's hospital boards emerged from my early field experience and from a fusion of the main theoretical analyses and empirical findings in the literature.

Initially, interested in reorganization as a social experiment in "participation", I focussed on such standard topics as change in composition, problems of "in-expert" participation, change in the nature of decisions made, and the like. My chief concern was with the newcomers to the boardroom scene. Ostensibly, the reorganization was going the route of so many other participation schemes: no overwhelming displacement of membership took place, the new members were largely impotent, and the "old guard" retained considerable control over board affairs.

It became clear, however, that an appreciation of what had changed with democratization could never be adequately achieved without knowing what the board was like *before* reorganization. At the same time, moreover, the anxiety expressed by administrators, physicians and former board members seemed out of proportion to the changes that, at least on the surface, had taken place. For these reasons I redirected myself to the examination of the traditional elite board system.

The literature, as I have shown, points to the social status of a board's membership as an important organizational

contingency. Emphasis has been on the *external* functions of boards, particularly on their ability to secure financial support for their hospitals. In Quebec, however, as I described in Chapter I, hospitals are funded by the State and their boards of directors are no longer "needed" for this important organizational function. This absence of the boards' traditional financial role in hospitals, combined with the resistance with which democratization was met and the ability of former elite board members to retain power within the "new" boards (see subsequent chapters), led me to ask what *other* functions the elite boards had been performing. Ongoing analysis of my field notes and the literature on hospital power structure suggested that elite boards may have performed important *internal* as opposed to external functions within hospitals. Specifically, I hypothesized that the social status of board members influenced the distribution of power within hospitals. The research objectives of this study, then, became:

(1) To describe the social structure of pre-Bill 65 "elite" hospital boards. How were board members recruited? How was board work carried out? What was the nature of the interaction between members? How did they perceive their hospitals and their role as trustees?

(2) To explore the significance of "elite" boards of directors for hospitals. What organizational functions did these boards perform for hospitals? Did elite

boards play a part in determining how power was distributed between the three major leadership groups in hospitals--physicians, administrators and boards of directors? How did they perform this function?

(3) To use the analysis from (1) and (2) as a framework for examining some of the outcomes of board "democratization". In other words, I attempted to understand how the former elite system worked in order to be able to appreciate the consequences of reorganization. How did incumbent hospital authorities respond to democratization? What did the new boards look like? What effect did the new membership have on the way boards operated?

CHAPTER III

RESEARCH METHODS

In this chapter I outline the research methods and materials used in the analysis. First, I discuss my sources of data: where my information came from and the methodological tools used to acquire it. Second, I discuss certain problems of access and the strategies I employed to resolve them. Third, I describe some interview techniques that I used in semi-structured interview situations and raise some issues related to these techniques. Fourth, I discuss two analytic approaches used in the study: the use of the constant comparative method and the ideal type. Finally I briefly outline the analysis to follow.

Sources of Data

Research for this study was conducted over a period of three years from 1973 to 1976 with most data coming from the first year and last six months of this period. Data were collected by review of documentary and other materials, by observation and casual conversation, and by formal unstructured, and semi-structured interviews.

Documentation and Other Sources

During the three years I monitored newspapers and such institutional documents as union circulars, newsletters of the

hospital "Corporation," hospital annual reports, government publications, legislative amendments and so on.

Observation and Conversation

I attended a variety of events such as patient elections, hospital public meetings, a labour union strategy convention, a seminar for administrators on consumer participation in health, and a variety of meetings of groups involved in board-related activities. At these events I questioned or chatted informally with participants, and, of course, recorded all conversations and observations in field notes.

Formal Interviews

Free-flowing and semi-structured interviews lasting from one to two and a half hours were conducted with a variety of individuals as indicated in Table IV.

TABLE IV

Number and Type of Full-Scale Interviews

Interviewee	Number of Individuals
Hospital administrators	10
Doctors	10
Board members:	
"old"	13
"new"	8
Others	9
Total	50

The term "hospital administrators" refers almost exclusively to the top administrative official in the hospital, usually called the "executive director". Each of these individuals, then, worked in a different hospital. The "doctors" were primarily department chiefs or senior administrators. Two-thirds of those interviewed formally came from three large general hospitals; the other third were senior physicians in a variety of other institutions including a small community hospital and a neurological specialty hospital. I attempted to select those physicians who were active and forceful participants in the highest administrative decisions of their hospitals. I did this by choosing physicians whom board members and the administrator had mentioned when discussing with me how and by whom certain decisions were made. That is, I sampled physicians on the basis of their organizational power as determined by "reference" or "reputation" (see the literature on locating community leaders, e.g. Freeman et al.'s (1963) comparison of alternative approaches). Consistency in the data from doctors resulted in relatively early "saturation" of concepts.

The "old" or former board members came from eleven different hospital settings. I shall discuss further on how these particular individuals were selected. The "new" board members interviewed were from three hospitals. Since there were relatively few "new" members, I interviewed all in each of these three boards.

The "others" category refers to a variety of persons connected in some way with boards and reorganization and includes government officials, a hospital consultant, employees of the provincial association of hospitals, union organizers and a president of a "Womens' Auxillary".

Institutional Setting

Formal interviews, observation and casual interaction were carried out in 15 different institutional settings. Ten of these were general community hospitals; the remaining five included a rehabilitation hospital, a neurological hospital, a government regional health office, the provincial association of hospitals and a union to which hospital employees belonged. Of the hospitals, three were French-speaking and nine were "anglophone" as defined in Chapter I.

Personal Experience

A source of data which is not always considered entirely legitimate in "scientific" enterprises (Douglas, 1976) but which nonetheless provided me with important information and insights, was my own cultural understanding of and experience in the upper class community to which many of my respondents belonged. I discuss this point later.

Case Study

In the later stages of the research field work centred on

three particular institutions. First, two large anglophone hospital boards were singled out for more in-depth comparative analysis because both were comprised of top-ranking elites but had widely divergent reputations for effectiveness. This comparison was used to highlight those characteristics of elite boards that were most closely related to their functions in the hospitals. Secondly, I followed in detail one board that was managing a crisis within its organization. It has frequently been observed that boards assume their major functions in times of organizational crisis, succession, or life-change (Mace, 1971; Zald, 1969). Consequently, I took the opportunity of studying how this particular board managed a public scandal concerning the chief executive and the accompanying unrest among the professional staff.

Problems of Access[1]

The relative scarcity of literature on society's higher social strata and on such organizational units as boards of directors is certainly related to difficulties of access. Boards of directors meetings are kept confidential and are conducted more outside the boardroom than within it. Moreover, directors and other members of the business and professional

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[1]Much of the material in this section is included in "Problems of Access in the Study of Social Elites and Boards of Directors", in Shaffir et al., in press.

elite are extremely busy, fast-paced individuals who have very little time to spare and who generally do not give high priority to being studied by social scientists. Executives, furthermore, are protected by secretaries or junior personnel who divert, discourage or refuse requests on their employer's time which they deem illegitimate or irrelevant. In other words, the researchers cannot just attend a board meeting, notepad in hand, and expect to observe what boards do. Nor can they reach a company president by just dialing the phone and requesting an interview.

My initial approach to the field research illustrates these difficulties. Introducing myself as a sociology graduate student I had limited success getting by the gatekeepers of the executive world. Telephone follow-ups to letters sent requesting an interview repeatedly found Mr. X. "in conference" or "tied up". When I did manage to get my foot in the door, interviews rarely exceeded a half hour, were continuously interrupted by telephone calls, and elicited only "front work" (Goffman, 1959), the public version of what hospital boards were all about.

By chance during one interview, a respondent discovered that he knew a member of my family. The rest of the interview was of a dramatically different quality than my previous data, and yielded particularly valuable information on the informal organization of board work.

The sudden richness of the data subsequent to my informant

discovering that he "knew" me reminded me of the importance of the researcher's *identity* in field research. Who I was, or was perceived to be, influenced the information to which I would be given access. The management of my identity thus became an important aspect of my research strategy.

Sampling Based on Social Ties

Abandoning my original intention of interviewing a representative sample of individuals from different institutions, I began to choose my subjects on the basis of social ties, seeking interviews with all those board members who personally knew me or a member of my family. I usually wrote a letter first, outlining my interests in a formal and business-like fashion consistent with how directors are accustomed to being approached as executives. Most executives and professionals such as these have large volumes of correspondence passing over their desks, much of which is "non-business" in nature, soliciting time, money, cooperation, information or whatever. Unless something attracts their attention as they skim through the daily mail, executives are quick to refer correspondence to the waste basket or to a subordinate to handle. In order to catch attention or to compete with other requests, I included personal references in my letter (such as, "I hoped you might have the time between fishing trips. . .", where I knew the board member often went fishing with a member of my family) and made certain my surname was written largely and legibly for them to recognize.

I succeeded in securing an interview in every case subsequent to my new approach.

Once having exhausted such direct personal contacts I asked those board members I *did* know to refer me to others they felt could help me (the "snowball" sampling technique). Sometimes they would call a colleague directly on my behalf, in other cases I found that "Mr. X suggested I come to you" obtained an interview, and, if I delayed a few days before the interview, I generally found that my new informant had made inquiries about me in the interim and established my identity.

The methodical use of personal social ties yielded substantially more informative and insightful data. "Referral" interviews were less productive than those drawing on direct social contacts but they remained superior to those where I was an unknown sociologist encumbered by the variety of stereotypes associated with such a label, such as radical, or socialist, or in any case someone likely to disapprove of the traditional elite board system. Table V gives examples from my field notes illustrating the nature of the data obtained under these different identities. The contrast is marked. Data in the left-hand column is largely "front work", bland commentary reflecting what the board member thought he ought to say or what I wanted to hear, and revealing little of the complexity of the social situation. Responses on the right are franker, less self-conscious, and expose some of the more subtle aspects of the board's social organization. The

TABLE V

Examples of Data Obtained Under "Known" and "Unknown" Identities

Response to an "Unknown" Sociologist	Response to a "Known" Individual
Board Member "A"	Board Member "B"
Q. How is the new membership working out? Any problems?	Do they participate?
. . . oh yes Mr. X (orderly) participates. He asked something today, now what was it? Sometimes they lack skill and experience, but they catch on. There is no problem with them. We get along very well.	Mr. X (orderly) hasn't opened his mouth except for a sandwich. But what *can* he contribute. . . ? You could rely on the old type of board member . . . you knew you could count on him to support you. You didn't have to check up all the time. But these new people, how do you know how they will react? Will they stick behind you? And there is the problem of confidentiality. Everything you say, you know will be all over the hospital ten minutes after the meeting.
Q. On the subject of administrator - board relationships.	
The board never does anything without first going through the administrator.	I met X (board member at another hospital) at the Club once and broached the subject with him. Once I got a general agreement I approached Y (administrator).

differences are not just due to a difference in the opinions of my respondents because in this case I had a second interview with board member A, this time under a "known" identity, and established that "backstage" he shared most of board member B's views.

I am suggesting, then, that the use of social ties as a research tool improved my access to hard-to-reach persons and their experiences. Why?

Friendship and Membership Factors in Access

Friendship norms were factors in my new-found access. In general, the closer the friendship tie with members of my family, the less frequently informants postponed or cancelled interviews, and the more "inside" information they allowed me. Two aspects of friendship may underlie this receptiveness: obligation and trust. Undoubtedly, certain of my respondents felt unable to refuse me because of their personal acquaintance with my family. This sense of obligation was sometimes reinforced by other social commitments, such as returning favours (e.g. a close relative had once found a job for a board member's son) or on-going business situations (e.g. one board member was in the midst of business dealings with a member of my family). A second element, trust, also helps explain the influence of friendship ties. Douglas (1976) suggests that suspicion and conflict of interest are inherent in all research situations and that people do not spontaneously reveal themselves

to anyone who asks. Clearly, if respondents are to relinquish backstage information about themselves they need to be confident that this information will not be used against them in any way. Friendship ties reduced the perceived risk associated with confiding to a researcher by acting as a form of security that information would not be misused or that boards would not be portrayed in an unfavourable light.

A second factor behind my improved access was my quasi-membership status in the social group I was studying. I grew up in the same social environment as most of the board members; my parents were part of the same social circuits, having gone to the same schools, or grown up in the same neighbourhood, or belonged to the same clubs, or attended the same parties, or done business together or, even, sat together on other boards of directors. Although I was not a board member myself, nor a businessman, nor even of the same generation as my respondents, I reaped some of the benefits of "insider" status by virtue of belonging to their social class, a social attribute I found was central to their function as board members. As with friendship, common class membership increased the level of trust in our relationship over that I could create as an unknown interviewer. Because I came from a known social milieu, I was more predictable to them; board members felt more able to anticipate how I would feel about certain issues, and felt I would "understand" their perspective and would present their points of view "fairly."

Membership as a Research Strategy

Neutrality and the elimination of bias are basic methodological concepts in sociology, a discipline striving for scientific legitimacy. Membership and the application of one's own cultural experience and understanding to research problems are often frowned upon as too "subjective" or "slanted". The use of natural experience, it is argued, biases the researcher's perception (the "rosy-glasses" argument, Douglas, 1976:113) and is vulnerable to self-deceptions. Consequently, when I first started my research I perceived my social proximity to those I was studying as a source of distortion, and I took great pains to conceal our common social ties from my informants, such as dropping my maiden name, and avoiding persons I knew would recognize me.

Some very penetrating social analysis, however, has been carried out by researchers who were "members" of the organizations or social groups they studied (e.g. Roth, 1963; Becker, 1963; Dalton, 1959). It is also perhaps noteworthy that, among the few who have studied the upper classes, some of the most valuable contributions I know of were made by researchers who came from an upper class background themselves (Baltzell, 1964; Ross, 1952, 1953, 1954, 1958).

In my study I felt that the advantages of "inside" status outweighed the risk of bias. I did, however, make special effort to remain constantly aware of the possible influence of such a status on my data and on my analysis.

Interview Techniques

A major objective of my research strategy was the suppression of front work. One tactic, as I have just discussed, was the use of friendship and social class ties to foster trust. The nature of interaction at the interview itself, however, also influenced the kind of information I received. Two types of tactic in particular were useful: "deflection" and "tracking".

Deflection

It sometimes proved useful to camouflage the real research questions, to "deflect" informants' attention away from the main targets of study. Because it reduced self-consciousness and perceived threat, deflection was a useful technique for subjects who were anxious about personal exposure. Many of my respondents became reticient when they perceived themselves to be the object of study, that is, when I told them I was interested in how the old elite board system worked. I found, however, that they were prepared to offer their views more freely on "external" topics, such as reorganization policy or problems of the new membership. Ostensible concern for new board issues deflected attention away from the elite system *per se* and made my respondents feel more at ease. At the same time, however, I was still able to elicit the kind of data sought because it was impossible to discuss the consequences of reorganization

without constant comparison with the past. Discussion of the new boards proved an excellent foil for investigating the former system. Indeed, a great many aspects of the "old guard" boards were never explicitly recognized until reorganization disrupted taken-for-granted patterns of behaviour.

Another way in which I deflected attention away from my main unit of analysis was avoiding the display of too much interest in bits of information that were "juicy" from the perspective of my analysis. Rather than raising my eyebrows and risk having respondents think they have been indiscreet, or that there was something unusual or bizarre about their behaviour, I tried to create the impression that the information did not surprise me and was not of *intrinsic* interest to me.

A further technique for deflecting attention off the main target of investigation was through the judicious use of note-taking. I never wrote continuously during interviews, recording only key words and phrases to jog my memory later. Occasional note-taking, however, made the movement more conspicuous and appeared to signal information of "value". A further "deflection" tactic, then, was not to indicate the importance of certain data by immediately recording it.

Tracking

While in some instances I found it useful to obscure what I was most interested in, it was sometimes more constructive to do the opposite. "Tracking" consisted of putting informants

on rathern than *off* the track; it attempted to elicit desired information by using cues that clarified rather than concealed the research objectives. "Tracking" did not mean, however, outright disclosure of working hypotheses. Rather, it referred to the communicating of selected information about the research that suggested to informants the *kinds of things* I was looking for. The most direct tracking device, of course, was explicit questioning, but, particularly in semi- or unstructured interviews too many questions were disruptive and less conspicuous tracking mechanisms were needed. Positive feedback was one such tactic. Expression of interest, such as nods, appreciative comments, note-taking and so on reinforced desired topics or directions and had the effect of gradually aligning my informants' inputs with my analytic categories.

I also "tracked" by the use of previously learned "inside" information. By incorporating bits of fact or detail or a name or incident into my questions or comments, I communicated a number of messages to my respondents. First of all, respondents learned what I already knew and were less inclined to "waste" time going over familiar points. I only used inside information in this way, of course, when certain categories were "saturated" (Glaser and Strauss, 1967), that is, when I no longer *needed* repetition. Secondly, dropping inside information made my informants better able to appreciate my level of analysis and hence make more appropriate responses. For example, most board members were businessmen, lawyers, or

financial men, who were not accustomed to providing the kind of information I sought. They presumed that "facts and figures" were wanted and tended to perceive their own ideas and experiences and many backstage details as either irrelevant or too trivial to bother mentioning.

In contrast to the strategy of "deflection" where subjects are seen as reluctant to reveal backstage information, this "tracking" method assumes that informants are basically willing to share information and that this cooperativeness can be harnessed by proper guidance. The strategic use of "inside" information in interviewing, however, was also effective where respondents felt ambivalent about talking too freely. First, respondents learned that I was "in the know", that I had penetrated through the public veneer to the underlying social reality. Front work was discouraged because they knew that I could distinguish it from backstage information and that it might look as if they were covering something up. Secondly, the use of insider details possibly acted to reassure reticent informants. I often had the impression that respondents felt relieved by the knowledge that they were not the only persons making such disclosures, that initial responsibility for having done so lay with somebody else, that this somebody must have had reason to trust me in the first place.

The use of inside knowledge, however, did have certain limitations. First, where I had assured my respondents that what they told me was confidential, the overt display of too

much inside information might have caused them to doubt the sincerity of such a vow. Consequently, I took care never to use details that were sensitive or which too readily could be identified as coming from particular individuals. Secondly, while my appearing "in the know" reassured some people, others felt less threatened when I played the "boob" and projected myself as rather naive and harmless.

"Deflection" and "tracking", then, are two techniques that improved my access to backstage information on elite boards. The tactics of each, however, have their *pros* and *cons*. The use of "dummy" research targets may have alleviated self-consciousness and allowed reflected images of otherwise inaccessible phenomena, but it sometimes precluded the advantages of direct questioning or of such tactics as the manipulation of "insider" knowledge. The use of insider information, in turn, generated trust, but it at times also eroded it. Playing the boob may have reduced suspicion, but it may also have encouraged frontwork. I found I had to remain constantly on the alert to avoid wasting the techniques' potential (using deflection with an uninhibited, cooperative subject), employing them in inappropriate places (displaying inside knowledge in conflict situations), allowing them to undermine each other (revealing inside information while playing the boob) or pushing them to the point of diminishing returns ("deflecting" attention so far from the unit of analysis that the data become irrelevant).

Conflict Versus Cooperation

"Deflection" and "tracking" were techniques that attempted to control front work, to reduce the extent to which respondents felt threatened or distrustful, and to harness whatever cooperation and goodwill respondents had to offer.

Douglas has criticized classical field research for assuming that informants will be essentially open and cooperative in imparting information and sharing their experiences. He proposed an "investigative" paradigm based on the assumption that,

> . . . profound conflict of interests, values, feelings and actions pervades social life. . . . Instead of trusting people and expecting trust in return, one suspects others and expects others to suspect him. Conflict is the reality of life; suspicion is the guiding principle. (Douglas, 1976: 55)

Essentially, I agree with him. In my research the act of board reorganization itself implied that something was lacking and undemocratic about the old system. This implicit accusation naturally put many of the "old guard" members on the defensive. Failure to appreciate the conflict of interest inherent in such a situation would surely have prevented me from achieving the trust and frankness essential to the study. For example, some of the details that interested me the most (e.g., informal decision-making processes) were those very aspects which, in the climate of Bill 65, board members were least disposed to reveal. Recognition of this conflict of interest

led to a more appropriate choice of interview strategy.

At the same time, however, I think Douglas goes too far in rejecting the notion of cooperation. To assume that certain individuals want to keep their beliefs or behaviours private is to make just as many a priori judgments as to assume they will willingly expose themselves. For example, one reason why boards of directors have not been widely studied may be that researchers *assume* that their activities are private and that board members will be tight-lipped. I found, in fact, that much of what goes on at the board level is "private" only because no one on the "outside" ever expressed any interest in it. Similarly, as I have already mentioned, many board members talked in general non-commital terms less because they were trying to conceal what was really going on, than because they simply had no idea what kind of information I was looking for. To assume conflict of interest in this case would have led to the use of a "deflection" or other indirect tactic where "tracking" techniques, which assume a cooperative posture, might have been more appropriate and productive.

In other words, I had to be cautious about making a priori assessments of what "ought" to constitute a conflict-suspicion research situation. The will to cooperate could be not taken for granted, but its absence was sometimes due to other factors than conflict of interest or fear of exposure. Moreover, individuals were not *either* trusting *or* suspicious. They were often both, being frank and open in one instance, evasive and deceptive in another.

Analytic Approaches

Two analytic devices in particular were used in this research: the "constant comparative" and the "ideal type".

The Constant Comparative

The overall approach to this research was through "grounded" field analysis. The collection of data was guided by constant simultaneous qualitative analysis of field notes. The discovery and refinement of categories and concepts and the generation of theory from on-going analysis of the data proceeded as outlined in the methodological essays of Glaser and Strauss (1967), Lofland (1971), Douglas (1976), and others.

The "constant comparative" methods of grounded research (Glaser and Strauss, 1967) were particularly important to my study. To understand the consequences of reorganization I needed to know how the former boards worked. Vice versa, however, the process of democratization was key to the study of the elite system because so many of its features only became visible in the context of reorganization. For example, many of the norms and practices of elite boards were taken for granted and emerged only as "old" board members responded to the new structure. The "constant comparative" method was ideally suited to such a research situation. The continuous cross-comparison of the elite and "democratized" board structures generated the analysis of each, and importantly, also

lead to my eventual recognition of the importance of their interrelationships for the outcome of "democratization."

The Ideal Type

Although it would appear to be a rather unfashionable theoretical approach in sociology at present, I have used Weber's "ideal type" in the analysis of elite hospital boards. The "ideal type" is a theoretical construct, a "pure case", a logically precise description of a social phenomena. The ideal type is rooted in the empirical world but because it is on a higher level of abstraction, it approximates rather than directly represents specific situations.

The elite board system is presented as an ideal type which is a generalized "pure" case distilled from the analysis of many different institutions. It incorporates the key attributes of elite boards, although it does not represent *exactly* any one board in particular. The use of the ideal type in such an analysis was useful as a conceptual tool for identifying the overall coherence of the system and for the comparison of different organizations.

Outline of the Analysis

Part I of this thesis has introduced the research problem by describing the social and historical context of hospital board reorganization, by discussing the relevant literature,

formulating certain research questions, and by outlining research materials and techniques.

The rest of the thesis is divided into three more parts. Part II is concerned with the organizational significance of the former elite boards and seeks to analyze how the elite system operated in the past and what its functions were for hospitals. Part III uses the frame of reference and findings of Part II to analyze some of the outcomes of democratization. It describes how board reorganization was carried out, and some of the changes that ensued within boards and hospitals. Part IV summarizes the arguments and attempts to interpret them in the light of broader social structures.

Originality of the Research

The originality of this study lies in its substance, its approach and its research methods. First, in terms of substance or subject matter, the study centres on a specific ongoing experiment in social policy that has been subjected to little empirical research. The few studies that have dealt with participation in Quebec's health and social service area either did not consider participation in much empirical depth (Renaud, 1977), or did not include anglophone institutions (Couture and Gravel, 1977), or were centred on health facilities other than general hospitals, such as the CLSC (local community health clinics) (Godbout and Martin, 1974). Origin-

ality also lies in the fact that this study explores two social phenomena that have not been widely studied by sociologists: upper class social life, and boards of directors.

In terms of *approach*, the study assumes a different perspective from most of the literature on the topic of "participation" in decision-making. First, analysis of the impact of participation is made not in an empirical vacuum, but in comparison with the previous system. Thus, analysis of the outcomes of the democratization of hospital boards is based on knowledge of the former elite board system. Second, rather than focussing on the newcomers to the decision-making context, this study is more concerned with the perspective and behaviour of incumbent authorities. Thus, the study's main units of analysis are the responses of administrators, former board members and physicians to the "democratized" boards and the influence of these responses on the outcome of reorganization.

In terms of methods the orginality of this work lies in the use of qualitative, "grounded" field research, a research technique and analytic approach that has rarely if ever been applied to the study of either boards of directors, social elites, or public participation. The practice of sampling on the basis of social ties is a further methodological distinction of the research that contributes to its orginality.

PART II

THE SOCIAL FUNCTIONS OF ELITE HOSPITAL BOARDS

The purpose of Part II is to describe those features of the former elite hospital boards that had relevance for the outcome of democratization. On the basis of my data and buttressed by findings of other researchers, Chapters IV and V analyze certain characteristics of elite boards and the functions they performed within the hospital. Empirically, of course, not all the boards in my study had identical social structures and functions. The analysis synthesizes the variation into an "ideal type" which would be found in its entirety in few individual cases but, because it contains those characteristics of most significance to the issue of democratization, it serves as a measuring stick against which to compare different hospitals and to understand their behaviour.

CHAPTER IV

THE SOCIAL ORGANIZATION OF ELITE HOSPITAL BOARDS

This chapter examines certain aspects of the social organization of the former hospital boards in order to understand the social processes that produced and maintained their elite composition and to identify the implications of such a composition for the way these boards behaved. The analysis focusses on the social incentives behind the participation of community elites, the recruitment of new members, and the characteristics of elite boards that were associated with these processes.

Social Incentives to Hospital Board Work

A number of social factors encouraged the participation of community elites on hospital boards of directors: leadership and class norms, friendship obligations, status and career payoffs, personal gratification, and various "structural" facilitators.

Leadership Norms

Despite a relative scarcity of research on the upper classes as a social entity (Domhoff, 1971), the literature frequently notes a relationship between voluntary participation in community organizations and leadership status. Members of the social

and economic elite have a high rate of participation in civic and social welfare institutions, with the highest status individuals often being the most actively involved (Perrucci and Pilisuk, 1970; Schulze, 1958; Hunter, 1953). In Canada, Clement (1975) found that 31% of the country's economic elite held a governing position in a private school, university or other institution of higher learning.

As noted earlier in the literature review, different types of elites attach themselves to different types of community organizations. The health sector, by virtue perhaps of its perceived intrinsic human "value" and the financial magnitude of its operations, attracts top-level community leaders. Elling and Lee (1966), for example, found that 77% of the leaders they identified in Pittsburg were connected with voluntary health co-ordinating agencies, with the same percent being on the boards of general hospitals. Clement (1975) found that over one-quarter of Canada's top economic elite (using more stringent criteria for "eliteness" than Elling and Lee) were on the governing board of a major hospital.

Clearly, the literature suggests that voluntary community work is a normative expectation associated with leadership status. As Ross (1954) and others have noted, many businesses and industries regard community work as "part of the job" of their senior executives and, by actively encouraging their employees to take on outside volunteer responsibility, essentially institutionalize the norm.

> You have to do these kinds of thing. You get stuck with it really. Being on the (hospital) board was part of my year as president of X (industry) at least that's the way I considered it. (BM B)[1]

These expectations appear linked to two social "functions" of hospital board work, legitimation and "showcase".

Legitimation. By implying generosity and community-mindedness, volunteer community work was perceived to assuage a negative public image of businessmen and professionals.

> It's important for people such as myself to do this kind of work . . . people tend to think we only have time for making bucks, that we don't care about other people. (BM B)

Blishen (1950) has noted that such community work as participation in fund-raising campaigns was seen as counteracting a public image of businessmen as selfish, while Form and Miller observed that welfare activities provided industrial executives with

> . . . secure and respectable status platforms which can free them from the accusation of ubiquitous self-interest. (Form and Miller, 1960:300)

This public relations function of hospital and other community work is related to the legitimation of power. Hunter (1953) has observed that public "service" (including hospital

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[1] "BM" = board member. In later chapters where both "elite" and "new" board members are quoted, "BM" refers to former elite members, while "NBM" will signify new members brought on after reorganization.

trusteeship) legitimates individuals' right to make decisions in other areas. Similarly, Vidich and Bensman (1958) suggest that, to be justified, power in the "primary sphere" (top-level economic and political decision-making) must be accompanied by leadership duty in "secondary positions" (such as welfare institutions and hospitals). In other words, participation in "public" institutions helps to legitimate generalized leadership roles.

Showcase. Such organizational settings as hospital boards operate as display "showcases" for the skills and competencies of their members. By conducting a successful fund-raising campaign, by adeptly chairing a board sub-committee, or by other visible displays of ability, up-and-coming executives can "prove" themselves in positions of authority above those they hold in their outside work.

> You could prove your mettle on the board . . . you could always single out those people who would go some place. . . . (BM O)

Several studies have found that community organizations are used by business and industry as training and testing grounds for potential executives (Form and Miller, 1960; Ross, 1954; Hunter, 1953). More generally, Presthus (1964) maintains that community organizations are "instruments for the circulation of elites", because leaders are recruited, at least in part, on the basis of their performance in public service offices.

One explanation, then, for the participation of elites on hospital boards was the association between volunteer public office holding and leadership status. Community involvement is a role expectation of leadership and appears instrumental in the legitimation of such leadership and in processes of leadership recruitment.

Class Norms

Closely related to leadership role was the more general influence of class norms on the community involvement of elites. Upper class traditions of noblesse oblige prompted individuals to feel an obligation to do such "service", and to see it as a duty of class membership.

> Everyone should do some community work. I was always brought up that way, to believe that it was the duty of our kind of people to contribute to the community. . . . (BM E)

> Most, including myself, feel that it is part of life's tasks to do this sort of thing. (BM O)

Presthus (1964) has noted this "feeling of stewardship" among elites, while others found that elites tend to perceive themselves as "benevolent providers" (Form and Miller, 1960; Hunter, 1953).

The perception of class obligation, although not always explicit, was nonetheless distinguishable in such data as

> I sort of felt I ought to accept (invitation to join board), I mean somebody has to do it! (BM L)

Sometimes, too, participation was expressed in personal rather than class terms.

> Basically I always try to have one thing going outside my practice. It's a way of doing your share I guess for the community. (BM B)

The use of the word "share", however, implied a sense of group responsibility, as did such phrases used in other responses as "pulling your own weight." Many of my respondents felt that *everyone* "ought" to "do their bit" but that it was particularly incumbent upon members of their social stratum.

The perceived obligation to perform community work was sometimes elaborated into a "volunteer-self" that was carefully apportioned.

> I like to do four things outside of work. I like to have something to do with education, something with sport and recreation like the X Club or the Y Tennis Club, something related to business but not directly to my own work, and then something in health and welfare. (BM O)

It has also been observed that elite participation in social welfare organizations is related to a class mistrust of encroaching government interference in the "private sector" (Form and Miller, 1960). This sentiment was also evident in my data, undoubtedly a response to the recent rapid and far-reaching expansion of government involvement in Quebec's health sector and intensified by strained English-French relationships, the political alienation of anglophones from provincial

affairs, and fear of the nationalist aspirations of the francophone population.

> The feeling is that *we'd* better be involved or by golly *they'll* just run the place like they run other bureaucracies. (BM P)

The italicized pronouns[1] demonstrate a we-consciousness and a class defensiveness in elite involvement in Quebec hospital boards.

In sum, then, it can be seen that certain class norms and beliefs sanctioned elite participation in such philanthropic enterprises as hospital boards. Participation may thus have functioned as an affirmation of class allegience.

Family and Friendship Obligations

Board members sometimes reported that they had joined the board because they felt unable to refuse the friends who had asked them.

> Well, you know, you get stuck with these things. There is nothing you can do about it. My father was a physician there, and my son did his internship there and some of my friends are doctors there . . . it's just one of those things, you can't refuse your friends when you're asked. . . . Pressure was put on me to come to the hospital, you can't turn down your friends. (BM B)

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[1] In this and all subsequent quotations from the field notes the emphasis is mine and is intended to draw attention to those words or phrases that best document my arguments.

Ross (1953) notes similar "coercion" through friendship ties in fund-raising campaigns where pressure to contribute was rendered almost irresistible when the canvasser knew the donor personally.

Other board members accounted for their participation in terms of preceding family involvement.

> I guess it goes back to my father. He was always interested in hospital work, particularly in the X, and a few years after he died I joined the board. (BM C)

Leadership, class, family and friendship factors in elite participation all created a perceived *obligation* towards community work. Other factors operated as *inducements*.

Social Mobility

Although a perceived sense of "duty" was a motivation behind elite involvement in hospital boards, the job was not without social payoff. Board work was associated with two forms of social mobility, occupational career and prestige.

Career. As has already been discussed, hospital board work was instrumental to the occupational career strategies of certain board members by allowing them to fulfill normative expectations of "public service" associated with leadership and to enhance their promotion potential through display of their capabilities. Board work also had more direct career benefits. Many board members confided that hospital and other community work was a useful way of "getting known". Working

on boards allowed them to make "contacts" that might prove useful to their outside work, and to acquire new clients.

> Apart from anything else, being on the board is a good chance to hustle some business . . . the more you get around and are seen about the more likely people are to think about calling you as opposed to somebody else when they need some legal counsel. Especially if they see you making a decent contribution on the board. (BM G)

For some women, particularly perhaps upper class women for whom community work functioned as a surrogate occupation (Ross, 1958), board work provided direct career opportunities.

> Membership on one board always seemed to get you invited on to a dozen others. Organizations are always on the look out for people willing to work and the more visible you are in the community, the more you are asked to do. (BM U)

Prestige. A less tangible form of social mobility accruing to hospital board work was the acquisition of prestige through association with high status board members.

> . . . there are several reasons why I joined, the first is that I thought it might be fun to do something for nothing and serve the community. That was a factor although it wouldn't be honest to say it was just that . . . it was also prestigeous, you know, you can't deny it, there is prestige attached to sitting on a board like this. There are nice people on the board, and you get a chance to meet them. (BM Y)

Kluckhohn and Kluckhohn (1947) have suggested that prestige can also be gained through association with high status institutions. Membership in an organization of high public esteem

confers prestige. Stinchcombe (1965) has noted the function of organizational affiliation as a "credit rating". Individuals are socially differentiated on the basis of the organization to which they belong. I found that where board members had offers to join several boards they usually always went to the most prestigious institution, certainly in part because of the esteem they could acquire from such an association.

The prestige incentive of board work may have operated in a way similar to Veblen's (1973) theory of "conspicuous leisure". Just as leisure is "evidence of pecuniary ability to afford idleness", so hospital and other community work may have implied a social or occupational status sufficiently elevated to permit the discretionary use of time. The exclusive nature of board work may also have promoted it as an insignia of elite status. Because an invitation was prerequisite to membership, being on a hospital board conferred prestige by implying social proximity to its high class membership.

Personal Gratification

Many board members found hospital board work personally satisfying. First, as other researchers have reported (Sills, 1957), board members enjoyed the experience of "helping", of performing what they perceived to be a useful task.

> You've got to feel as though you're doing something, something of use to somebody. (BM L)

To most board members, hospitals had obvious social "meaning" by virtue of their association with the generally hallowed institution of medicine and with such emotionally charged issues as disease and death.

A related sentiment was the desire to "feel needed". Board members derived satisfaction from perceiving themselves as necessary. Formerly, of course, their direct financial importance to the hospital contributed to this psychological incentive to participation, but the arrival of state-financed care and the progressive centralization of policy-making in Quebec had been making many board members feel increasingly irrelevant or even dispensible.

A second type of personal gratification accruing to hospital board work was intrinsic interest. Several board members, for example, expressed enthusiasm for hospital work because it was novel and stimulating to them.

> The hospital is so complex, much more complex than any business in my experience. And the doctors, everyone is such prima donnas! Business boards make very few decisions. We do much more at the hospital. (BM M)

Indeed, numerous board members centred their post-retirement "careers" around this interest.

> I think I am most fortunate to have something to do after retirement that is both interesting and useful. (BM P)

It was common in elite boards for members to become "active"

upon retirement and to take on time-consuming responsibilities, such as becoming board president or chairman of a key committee. This practice provided the hospital with board members who had sufficient free-time to participate effectively in hospital matters while giving board members "something to do" after retirement. Some of these "career" trustees spent several hours a day on hospital affairs.

Structural Support

The variety of incentives behind elite participation in hospital boards discussed so far were supported by several structural aspects of their social situations. First, we note that senior executives and professionals (and certainly "independently wealthy" or "coupon clipper" board members) had considerable control over their time. They may have been very busy people, but they were less tied than others to the work site during work hours. This discretion over their own time undoubtedly facilitated voluntary participation in community organizations. Moreover, the time they did contribute was *paid* time; companies in effect, donated the time of their executives to community affairs and they often supported such activity through provision of secretarial help, stationery and other office services. Executives sometimes reduced the time demands of board work by the use of personal or company chauffeurs (e.g. to circulate a document for signatures rather than calling a meeting). Furthermore, because elite board members often

belonged to the same clubs and worked near each other in the centre of town, "meetings" could consist of lunch-time get-togethers which eliminated some of the necessity for formal, time-consuming meetings or trips to the hospital.

In summary, then, a number of "incentives" lay behind the involvement of community elite in hospital board work. Leadership, class, and friendship obligations encouraged elites to engage in "public service" while career and prestige rewards and personal gratification compensated them for doing do.

The social inducements to participation were closely related to a second issue in the analysis of elite hospital boards--recruitment.

Recruitment

Elite hospital boards generally had from 12 to 20 members. A few hospitals had by-laws that limited the terms of office of its governors, but more usually members remained on the board until they resigned or died. It was not uncommon for individuals to be trustees for ten or fifteen years. Vacancies, then, did not occur frequently; usually only one or possibly two positions needed to be filled each year.

There were two main approaches to the recruitment of new board members, the "personal" and the "institutional".

The Personal Approach

Most often, friends, acquaintances or kin of incumbent board members were proposed for membership.

> We would set up a sort of nominating committee, nothing formal really, and somebody usually knew someone who was interested or available to come on. (BM C)

Since the only persons suggesting names were the existing board members, these proposed candidates were invariably known personally by at least one, usually more, members.

The Institutional Approach

Sometimes the boards felt they needed someone with a particular skill, such as a lawyer or an accountant. If no one could come up with a "personal" proposal, hospital boards would sometimes solicit candidates from certain companies, banks, or professional firms.

> They were looking for a lawyer, so they asked the firm of Smith, Jones if they could provide anyone. I did the same thing for the board of X University and for the Y Centre--I asked the Bank, who is a client of ours, if they could refer us to some recently retired people. . . . (BM D)

Companies and firms often had established philanthropic associations with particular hospitals.

> We always had people on the boards of the X (hospital). It was sort of a tradition I guess. (lawyer)

These institutional ties were perpetuated by the "personal"

processes of recruitment characteristic of these boards.

> The senior partner was on the board, and he was about to retire. He asked me if I could carry on. I more or less replaced him. (BM S)

and by the company's interest in maintaining such affiliation (public relations, executive testing and so on).

Formally, most boards had nominating committees but often the process merely consisted of the president drawing up a list of proposals made to him by individual board members and consulting his "executive" or closest board colleagues before the final choice or before seeking outside suggestions. If several candidates were proposed, the preference of the president or other influential board member seemed to prevail. The social homogeneity of the board (to be discussed later) apparently minimized dispute over who was recruited; that is, the tastes and perspectives of board members were sufficiently similar to ensure relative agreement over candidates and most minor conflicts of interest, as far as I could determine, were handled amicably.

> I would quite like to have seen X brought on the board, but some of the others disagreed. I didn't insist, there's no point creating division over things like that, you've got to work together. (BM C)

The next step was actually to invite the new board member to join. This was usually done through whichever board member had the closest social relationship to the recruit rather than

bureaucratically through the board chairman.

> We would discuss the various possibilities and then decide and someone would say 'well, so and so, you know him best, why don't you approach him?' That's the way these things are done. (BM C)

Because both the personal and institutional approaches to recruitment tended to select out those persons most likely to be interested in such work or to feel socially constrained to do so, invitations to join the boards were rarely refused. Those approached typically expressed initial hesitation and conceded to join after appropriate persuasion. This "reluctance ritual" as I might call it, has also been noted in other spheres of elite community participation (Ross, 1954, Hunter, 1953) and possibly functioned symbolically to deny the honour-privilege aspect of board work in favour of projecting an image of self-sacrifice and public "service". A similar norm was the impropriety of soliciting one's own board membership: it was not considered appropriate to ask to join a hospital board. Individuals had to wait until they were invited to join,[1] although there was some evidence that informal "cues" were used to provoke an invitation, such as letting a board member know about an impending retirement, a resignation from another voluntary position, or other indicators of "being available".

The names of individuals expressing interest were presented

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[1]Ross (1954) notes the impropriety of overtly seeking chairmanship of community fund-raising campaigns.

at the annual meeting of the hospital "Corporation" which typically was attended by a dozen, sometimes more, "governors" (financial patrons of the hospital) who were interested enough to turn out for the meeting. Proposals were never questioned here, and the new appointments were formally ratified.

Recruitment and appointment matters in general were always handled quietly and with decorum and the "election" aspects of the process were suppressed because a contest for membership was considered unseemly (as was also the case in the boards of Moss et al., 1966). This social practice reflected the board's perception of itself as a philanthropic enterprise. Competition for membership would have implied that the interests of the board member were more at issue than those of the hospital. Such a custom also reflected the underlying conception of hospital board work as a private privilege rather than a public right.

Selection Criteria

As just described, a personal or institutional connection with the hospital board was usually a prerequisite of membership. A number of other considerations came into play subsequent to this initial selection mechanism.

The most explicitly conceived and expressed selection criteria were "knowlege" and "expertise". Many hospital administrators and board committees made active use of their "in-house" skills, and boards often deliberately sought members

who could advise on construction projects, labour relations, financial management and other areas of relevance to the hospital. The study suggested, however, that the overt emphasis on expertise was as much an ideological justification as an active factor in the recruitment process. Expertise was perceived as the most socially legitimate selection criterion, emphasizing as it did the rational, bureaucratic aspects of board work. Other qualifications often carried as much--sometimes more--weight than expertise. Board members were less inclined to discuss these attributes either because they were not explicitly aware of their role in selection, or because they appeared inconsistent with normative conceptions of what a board of directors "ought" to be.

Sometimes board members qualified their rhetorical "knowlege and expertise" response by referring to the need for a more generalized, theoretical skill usually described as some sort of "judgment" or "experience".

> Special skills are necessary, but mostly it's enthusiasm and *judgment*. (BM P)

> We chose people who have had a wide range of *experiences* not for some specific know-how. (BM W)

These attributes, however, often referred implicitly to particular types of social experience, as illustrated here.

> You also need the specialized know-how of the board, not know-how like someone to fix the radiology equipment or something like that but *a certain life experience, experience in business or professional life.* (BM W)

In other words, experience and judgment were perceived as the wisdom acquired through organizational leadership. This criterion justified to themselves the choice of new board members from within the social circles of the existing membership.

New board members were also selected for their institutional connections, such as where they worked, who they knew, or what other directorships they held.

> Smith was brought in, well, because of himself of course, but also because of the National Bank, he is president. . . . (BM C)

Or, sometimes board memberships were offered as symbolic gestures of gratitude and answerability for financial support for the hospital.

> Last year we brought on John Smith. His family have given so much money to the hospital, it seemed appropriate for him to be invited so they can at least see how we spend their money. (BM J)

Another recruitment consideration was social compatibility. Board members frequently commented on how important it was for individual members to "fit in", to "think on the same wave length" to "speak the same language". Decision-making was facilitated, board members maintained, if members were socially at ease with each other.

The recruitment of new board members, then, was based on a number of considerations. Technical expertise, the most often cited criterion, was certainly considered a desirable credential, but it was often secondary to such social attributes

as executive status, relationship to important organizational contingencies, and social compatibility.

I now look at how the social incentives underlying board work and the nature of the recruitment process influenced the behaviour of board members.

Elite Board Behaviour

Three groups of consequences arose from the processes underlying elite involvement in hospital boards: social homogeneity, commitment, and "carry over".

Homogeneity

The characteristic of elite hospital boards of most consequence for the way the boards operated was their internal social homogeneity. Boards functioned in certain ways because their members all came from similar social milieux.

The first important social correlate of homogeneity was *normative agreement*. Board members shared a common *Weltanschauung:* that is, they tended to have similar views on their philanthropic role in public service institutions, and on the hospital's mission in the community and they agreed on such issues as the evils of government involvement in the "private" sector, the value of technological medicine, and so on. By virtue of their common experience on business boards, many board members also shared certain ideas about the role of boards of directors

and the conduct of individual board members.

The normative agreement evident in the interview data was supported by the fact that many policy questions concerning internal board organizations were raised for the first time after democratization, suggesting that the behaviour of board members had previously been governed by shared norms. One example is the matter of confidentiality (to be discussed more in a later chapter). Elite boards had rarely if ever raised the topic of what business should or should not be made "public": board members were presumed to know by intuition, experience or upbringing what information required "discretion".

Although, of course, not all board members had identical beliefs or styles of behaviour, I found in general that their values were ideologically compatible and that they agreed on the basic social parameters of board work practice. This finding is hardly surprising in the light of the structure of incentives and patterns of recruitment underlying their involvement.

A second consequence of homogeneity which is associated with normative agreement was mutual *trust*. Because they were operating within the same behavioural code, board members could anticipate and rely upon the activities of their colleagues. Moreover, trust facilitated delegation of responsibility between the board and its executive.

> They (active board members) had *the complete moral backing of the rest of the board* who were prepared to be

> members but not willing to devote too much time to it and were only too pleased and grateful to have someone take this responsibility. Other board members supported those who took the responsibility. (BM W)

Most decision-making was done by the president and one or two "active" members, or committees. Because board members had confidence in each other, executive or committee decisions were rarely questioned when brought to the full board for approval.

> Committee decisions are usually always ratified. They know the facts, they reached the decision--the board's not in a position to question. But that's why we appoint the right people to the committee in the first place. You trust them to make a decision that reflects the board's position. (BM S)

Another important correlate of homogeneity was *informality*. Most board-level deliberations and decision-making went on informally, outside the boardroom and free from the confines of motions, minutes and agendas. Because many board members were personal or business friends, they had access to each other outside the boardroom. They often met over lunch, at clubs or at private parties, all of which provided occasions to discuss hospital affairs in a relaxed and casual fashion.

> I walk down to work with X (fellow board member) every single morning, and we often chat about the hospital. . . . Y and Z (other board members) I see virtually every day at the Club. (BM M)

From the point of view of busy senior executives, this arrangement saved considerable time as business could be conducted

between monthly meetings and without having to go to the hospital.

The telephone was also an important part of this informal administration. Because board members knew each other personally and were usually of similar hierarchical rank within their organizations, they were able to call each other without interference from secretaries and without violating norms requiring communication to remain within status levels.[1]

Informality not only characterized decision-making in elite boards, but was also an important aspect of internal social control processes. Few formal rules guided board member behaviour and control was a function of status and interpersonal relations. Ross (1953) has noted that volunteers in fund-raising campaigns complied with instructions largely because of friendship constraints and out of deference to the social prestige of the organizers. A similar kind of social control characterized elite hospital board work.

> No one questioned X (board president), he was a pretty big wig and no one really felt they could question him, particularly the more junior board members. (BM O)

> If you get 15 or 20 of this calibre people (executives) who have great respect for each others'

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[1]It has been observed that within organizations communication is mostly lateral rather than vertical. Presidents deal with presidents; middle management with their hierarchical counterparts in other departments or organizations (e.g. Blau and Scott, 1962).

> ability, there is no trouble getting a hearing for anything, it is very clear what the function of the board is. . . . No adversary positions are taken. Nobody feels that he is absolutely right and that everyone else has to be compelled by it. (BM W)

Dissension between board members was minimized by their similar social attributes, outside status distinctions, and vested interests in maintaining amicable relationships with friends and business associates. Such informal control mechanisms also ensured that the board would support executive or committee decisions.

In notable contrast to these informal aspects of board work was the observance of formal business etiquette at meetings. "Mr. President" often replaced first names, motions were proposed and seconded on the most routine and uncontroversial matters, and other formal rules of order were closely followed. This adherence to formal procedures was in part a reflection of the business orientation of the boards' membership and of the historical origins of such philanthropic enterprises. It may also have been an example of Goffman's "impression management" or "front work" (Goffman, 1959) whereby the board observed formal business etiquette to sustain a public image of themselves as serious, responsible and "democratic". Board members were frequently reluctant to discuss the informal nature of much board work. Many board members tried to qualify their accounts with such comments as "it sounds like a club operation, but it's really not", suggesting that they perceived informal board work as somehow illegitimate or unethical.

Apart, then, from its more obvious bureaucratic uses, procedural formality may also have functioned as a team front.

In sum, social homogeneity was an important characteristic of elite boards. It was at least in part responsible for a common *Weltanschauung* among members, a high level of interpersonal trust, and the informal social processes of board work.

Institutional Commitment

A second feature of elite board behaviour was the commitment of members to the hospitals they governed. Board members often identified closely with the hospitals' development and well-being and their commitment had certain organizational consequences for the hospital.

Many elite board members related possessively and sometimes paternalistically to "their" hospitals.

> Ils prenaient tout ça à coeur . . . la boîte leur appartenait; tout ce qui passait ici était leur affaire. . . . (Administrator G)

Possessive pronouns and expressions of social intimacy reappeared often in the data.

> . . . you know, I am very fond of *our* hospital, I have been here a long time, I know my way around here. . . . (BM F)

Board members became very loyal to their hospital. Not only did they limit their philanthropic interest to the one hospital but they also sought personal medical care there for them-

selves and their families. They rarely "switched" allegiances.

> They (board) lured me over to the Western Hospital from the Riverside. I had always been associated with the Riverside--my father sat on the board there, my son interned there, our family physician is there. (BM P)

Board members appeared to derive considerable vicarious satisfaction from the perceived achievements of their institutions.

> The government has used our hospital as an example of how things ought to work, the ideal, so-to-speak. (BM O)

This pride was often suppressed or qualified by board members to avoid appearing self-congratulatory.

> I don't want to sound as though I'm bragging but our hospital has a very high reputation. (BM L)

This identification with the hospital was both a consequence and a cause of the long terms of office of elite board members. Because members identified so strongly with the organization and drew satisfactions from it, they tended to stay on the board for many years. At the same time, the longer they were on the board the more they became involved in and committed to the hospital.

Commitment was also a function of organizational involvement. The more board members were actively engaged in on-going organizational affairs, the closer their relationship to the hospital appeared to be. Indeed, administrators recognized that often "meaningful" involvement in hospital affairs was a

precondition for the sustained interest and loyalty of certain board members.

> You've got to keep them (board members) interested. You've got to give them jobs that they like, draw them into working committees. You can't expect someone to come up from his downtown office and sit around listening to a chairman of a committee do all the talking. They have to be able to participate. (Admin T)

Committees were widely used as a mechanism for generating institutional commitment in board members.

The loyalty of elite board members to their particular institutions had certain implications for hospitals. First, it indirectly promoted a certain administrative competence. Eight to ten years was often cited as the term of office needed to acquire a "reasonable" amount of knowledge and experience to meaningfully participate in hospital decision-making. By encouraging long terms of office, commitment to the hospital increased the likelihood of members acquiring enough unterstanding to be administratively useful. Considerable time and effort went into "training" board members--such as placing them as observers on key committees, tours, lectures and so on--and the executive cadre was often structured so that the vice-president "learned the ropes" and "graduated" to the presidency. This kind of schooling and "career" was only feasible if board members could be relied upon to stay with the job.

A second implication of commitment was institutional rivalry. Intense inter-hospital competition was a corollary of

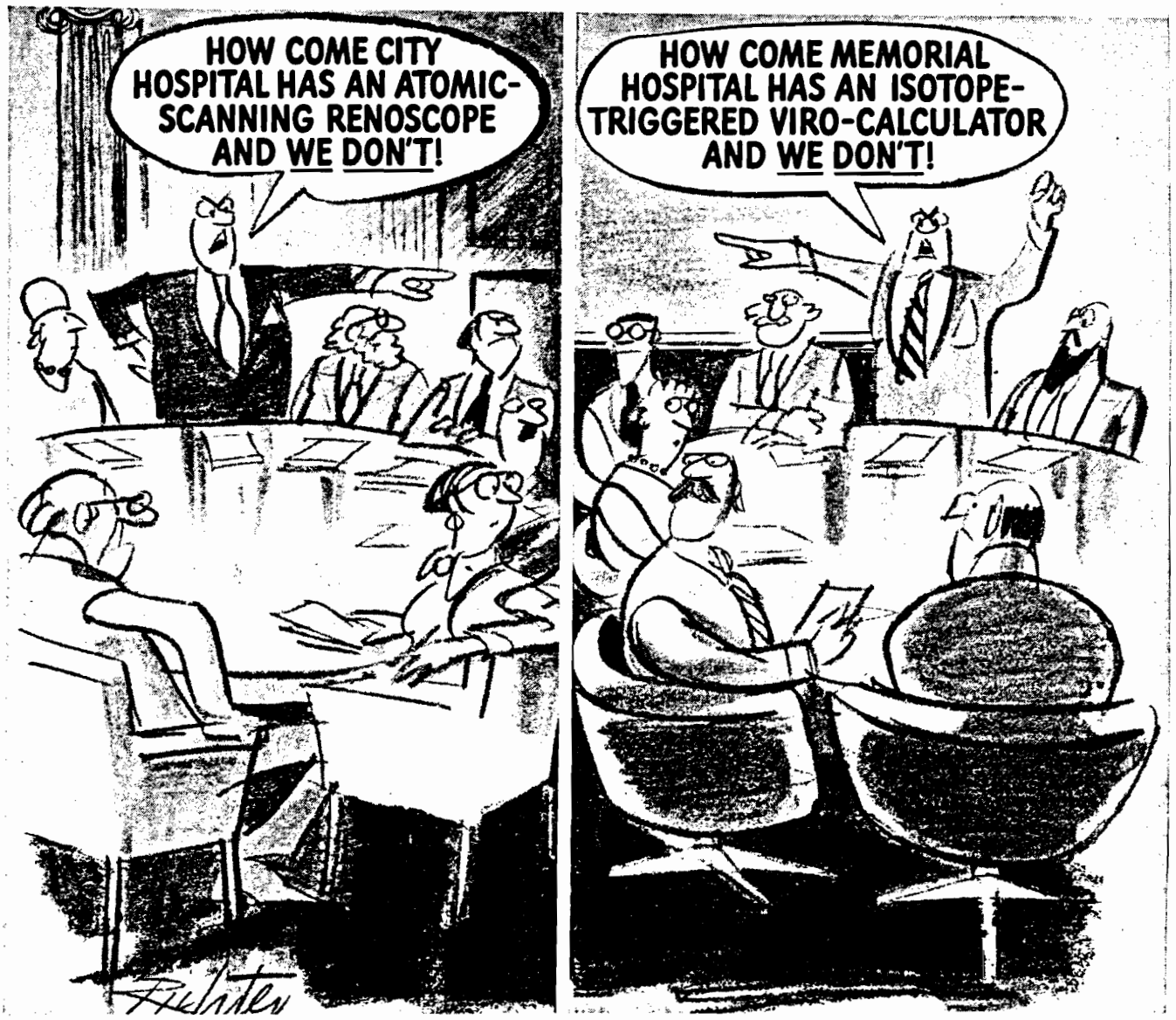
intense institutional loyalty. Hospitals have always competed among themselves for financial support, patients and doctors. Because the board had been so instrumental in the securing of these resources, it was unavoidably involved in this competition. Evidence of this rivalry lay in board members' constant reference to other hospitals, and in the language they used to describe these relationships. For example,

> Smith's family had always been associated with the Riverside but he retired and we thought we might be able to *lure him into our camp.* (BM L)

Competition is also reflected in the distribution of major capital equipment between the various hospitals. Hospital boards and their corporation patrons tried to secure the latest most advanced medical technology for their hospitals. They were proud when they were the first to have a dialysis unit, a cobalt bomb, or whatever. It was often rivalry that lay behind the purchase of such machinery rather than any rational planning or considerations of community need.

> Some boards are very difficult to work with . . . they are always trying to be better than the next hospital, so they say we're going to run our own show so to hell with you. They aren't interested in planning. (BM O)

Consequently, elaborate equipment sometimes lay idle because of insufficient patients or because of technical difficulties that prior consultation might have averted. The accompanying cartoon from The New Yorker illustrates this competition well.


HOW COME CITY HOSPITAL HAS AN ATOMIC-SCANNING RENOSCOPE AND WE DON'T!
HOW COME MEMORIAL HOSPITAL HAS AN ISOTOPE-TRIGGERED VIRO-CALCULATOR AND WE DON'T!

This avenue for inter-hospital one-upmanship has recently been thwarted by increased government control of capital development. However, because it was a social by-product of elite participation, rivalry was not eliminated but was merely transformed into competition for government support or approval.

> We invited some people from the Ministry to come and talk . . . the government really appreciates what we do here . . . some of my friends in other hospitals don't like this. They think we are sucking up to the government. (BM M)

Hospitals were not in "equal" competition with each other. A prestigious teaching institution was not in the same resource marketplace as a small community hospital. Board members thus compared their institutions with those hospitals in closest status proximity to their own, or possibly with those of higher status. Where hospitals were very similar, competition was sometimes intense.

> There is almost pathological competition between us and the X hospital. They just hate each other . . . if we ever say to the board let's go over to the X and find out how they're doing things, Y (administrator) won't have anything to do with it. There is tremendous antagonism. Z (board member) hates the place's guts ever since they tried to get the joint laboratory project going and failed. (Dr. K)

Board members, however, generally tended to view competition as unsavoury and denied or downplayed its existence.

> We have the lowest cost per day and yet we are one of the busiest hospitals. We have more patients a day than the X, which has a bigger budget. We're

> not in competition, of course, but people can take pride in that kind of thing can't they? (BM P)

When I asked questions about other hospitals or about a board member's opinion on the operation of other boards, respondents often skirted around the subject or even grew visibly uncomfortable. This normative suppression of competition probably related to the fact that inter-institutional rivalry was ideologically inconsistent with the philanthropic image of board work and to the fact that the business and social ties of board members ran across different hospital boards. Board members were reluctant to criticize institutions associated with their colleagues and friends. Group solidarity functioned here to reduce public display of rivalry, which in turn reinforced this cohesion. More formal mechanisms also existed for suppressing competition and conflict. For example, boards of "sister" hospitals were often invited to send a representative to the hospital corporation's annual meeting, a gesture that was rarely made use of but which endorsed a public image of disinterested and cooperative community service.

The nature of elite involvement in hospital boards fostered this inter-hospital competition. Personal identification with and pride in the hospital were factors as were also the "showcase" functions of board work in which board members were largely evaluated on the basis of hospital performance, giving board members a certain vested interest in the superior functioning their hospital relative to others.

Carry-Over

The social structure of elite board work had a third set of consequences for board behaviour. Board members "carried over" or brought with them from their outside social and occupational lives a number of attitudes and practices that influenced the manner in which business was conducted and the relationship between boards and hospital administrators.

The outside executive experience of many board members influenced their behaviour on hospital boards. One example of this was many board members' desire to be "relevant" and involved in decision-making because they were accustomed to such centrality in their outside jobs. Another example of carry-over was what was seen as a "managerial perspective". Sometimes board members described this attribute as being essentially an understanding of such executive issues as finance, budgeting, and personnel, but often it was perceived as resting more on form or "posture" than on specific skills.

> Board meetings are not meant to be endless affairs. They last from 2 to 3 hours. Certain things are put on first as they must be dealt with legally by the board, so we do them. But it requires great *discipline*, compactness to which this kind of a board member is accustomed, and all of them have learned to say something in *the least verbose way*, so no time is wasted. (BM W)

Executive posture also encompassed belief in the delegation of authority and in the independence of the chief executive officer. Board members firmly maintained that they should not be drawn into operating decisions, that they must leave day-

to-day decision-making to the hospital's administrator to whom responsibility was delegated.

> I don't have an office up there, if you do you are involved in the day-to-day running of the place and this I don't want to do. The first job of the board is to pick an executive director. Not to do his work, but to pick him and support him. (BM P)

Non-interference norms also applied to clinical decision-making. Elite board members were very respectful of professional expertise and deliberately avoided involvement in "medical matters". The implications of these norms of non-interference will be discussed more in the next chapter.

"Carry-over", then, refers to the effect of outside occupational experience and shared norms of executive behaviour on elite board members' style of conducting board affairs.

Summary

This chapter has examined some aspects of the social structure of elite hospital board work. A variety of social incentives lay behind the participation of elites in these hospital boards including leadership and class norms, family and friendship obligations, career and status payoffs and personal satisfaction. Recruited through personal and institutional channels, new board members were selected as much on the basis of specific administrative skills as on their social compatibility with other board members and on their conformity to executive behav-

ioural expectations. Elite board members tended to recruit other elites to the board because they found it more pleasant and efficient to work with people they knew, understood and trusted.

The nature of the incentives underlying the involvement of elites in hospital boards and the process of member recruitment had several consequences for how such boards operated. The boards' homogeneous composition led to normative agreement, interpersonal trust and procedural informality. Strong institutional identification and loyalty promoted administrative continuity and competence at the same time as it fostered inter-hospital rivalry. Board members conducted business in a fashion that reflected their outside occupational values and practices.

Three general observations are distilled from this analysis. First, before Bill 65, hospital board work was an elite *institution*. That is, board work had an organized social structure characterized by a shared set of values, attitudes and behavioural norms.

Secondly, many aspects of board work were closely linked to external social structures. The incentives for participation and the processes of recruitment and decision-making were all influenced by the outside social roles and relationships of the board members.

Thirdly, the way in which these boards operated was closely related to the social structure of its membership. Key

characteristics of this structure were shared or compatible beliefs and practices, a high level of interpersonal trust, internal social control, executive and managerial experience, and informal patterns of decision-making--all correlates of the homogeneous character of the boards and of the members' elite social status.

The social organization of elite boards, however, had consequence not only for internal board processes and practices, but also for the distribution of power within the hospital's leadership structure. This will be the focus of the next chapter.

CHAPTER V

ELITE BOARDS AND THE DISTRIBUTION OF POWER IN HOSPITALS

This part of the thesis is concerned with the social functions of elite hospital boards. The last chapter described the social structure of these boards and their significance for the community's upper class. This chapter relates this structure to the social functions which boards performed in hospitals. First, it looks at the issues of power and organizational control in hospitals and their relevance to administrators, doctors and boards of directors. Then, the chapter examines the relationship between administrators and boards and between physicians and boards. Lastly, the chapter discusses certain problems administrators face in trying to explore the social functions of their elite boards.

Power and Control in Hospitals

As I discussed in the literature review, the issue of power is central to hospitals because of their particular organizational and professional structure. The ability to influence decision-making is a matter of prime concern to the three major hospital groups and the pursuit of this control is the source of continuous negotiation between them. The importance of power in the social organization of hospitals was also evident in

my data. Administrators, doctors, and board members, all tended to perceive their work and interrelationships largely in terms of control.

Administrators

In response to the question "What is the most difficult part of your job?", administrators almost always spoke in terms of establishing, reinforcing, or increasing their personal control over what they saw as major hospital contingencies: the government, the doctors, and the board of directors.

All administrators interviewed felt their autonomy was undermined by the involvement of the provincial government in hospital affairs.

> . . . at the end of the day I used to feel as though I really had accomplished something. I don't feel that any more. There just isn't the self-satisfaction there used to be. It used to be a real challenge to your intelligence, your ability to work. . . . Now you are told how to do everything. Reams of paper comes from Quebec telling me what to do. (Admin A)

> I feel manacled, there are just so many government regulations and instructions. You can't do anything on your own. (Admin C)

Administrators also felt constrained by the hospitals' medical staff whose cooperation was critical to the hospitals' operations but whom they saw as resistant to organizational restraints on professional practice.

> There are hundreds of physicians working here, but they are autonomous, they have shared loyalties.

> When it is convenient they use the hospital as base; at other times if things get tight here they use the university. They are trained as loners. They don't like anybody looking over their shoulders. The internists would take over the whole hospital if they could, not consciously, of course, but because they see their needs as the most important. (Admin R)

Administrators often reported that physicians "obliged" them to make certain decisions on the basis of clinical considerations whose legitimacy they sometimes suspected but which they were powerless to supercede. As one physician-administrator remarked,

> One advantage to wearing two hats (being a physician and an administrator) is that *the boys can't and won't try to snow me*. (Admin C)

A further constraint for some administrators lay in their boards of directors. For example, sometimes their organizational control was restricted by a board president who was particularly knowledgeable or had a very forceful personality, or by board members who were very involved in hospital affairs.

> When I first joined the board the president was an old gentleman who was retired and he was there all day, every day. That's where his office was. He literally ran the place. The executive director (administrator) was his secretary. (BM C)

> Sometimes board members get right into things and can be very disruptive. Once someone wandered around the wards picking on a nurse here and there . . . if he has these complaints he can bring them to me, not to the nurses. You can't have this kind of interference. (Admin E)

More usually, however, administrators did not feel that their

boards exerted much influence over them, although they clearly recognized the board's potential for control and felt that the board had to be managed in such a way as to minimize its power over them.

Doctors

The problem of control also concerned the hospitals' medical staff. Many physicians perceived the hospital as centered around their professional practices and relegated organizational and other goals to a secondary level of concern.

> As far as I am concerned the hospital exists for doctors to cure patients in, and that's it. (Dr A)

Many doctors resented being "blocked" by budgetary restrictions, lack of space, bureaucratic procedures, or the demands of other hospital employees, and they centred their frustration on the hospital administrator whose job it was to reconcile such competing interests.

> It takes forever to get anything done around here. But the administration grows bigger and bigger, and there is more red tape. We've been fighting for an X machine for years now, but no way. These guys are just incompetent. (Dr A)

Although the degree of conflict varied, most of the physicians I interviewed expressed concern over what they saw as loss of control from the professionals to the administrators.

> Residents and interns see the administrator as against them. It's us against them. The upper medical staff

> also feel that way, they feel as though the administration were cramping their style, overzealous to balance their books. (Dr B)

Board Members

The issue of power was also relevant to board members, although less so because they had less at stake in the hospital than did administrators and the medical staff. Although boards constitutionally held ultimate organizational authority, in practice their power was limited by their part-time, volunteer character.

> The demands of the job (board work) are such that if you don't have a lot of time to give, everything will be done by the executive director and the board has no control over anything. (BM S)

Board members said they had difficulty becoming and staying "informed" on hospital matters and recognized their dependency on the administrator for most of the information to which they had access.

> We get all our information from the general manager. You have to rely on him, what else can you do? (BM Y)

In addition, the boards' control over the medical staff was limited by members' unwillingness to get involved in medical matters which they perceived as beyond their competence.

> I never interfere in medical issues. The doctors are the ones who know best and I'm not in a position to judge what they are doing. (BM S)

Problems of control, then, were common to administrators, medical staff and boards of directors. Administrators were concerned with their ability to handle increasing government involvement in hospital affairs, to manage a powerful and largely independent professional staff, and to maintain their autonomy vis à vis the board of directors. The medical staff were anxious to preserve their clinical independence and minimize organizational constraints on their work. The boards were concerned with their ability to exert control over the hospital from a marginal organizational position.

The next question, of course, is how were these issues of power resolved? How did administrators maintain some degree of organizational power and autonomy on such a crowded leadership stage? How did physicians manage organizational demands to further their professional ends? How did boards of directors influence hospital decision-making with such limited organizational involvement?

My research indicated that an elite board of directors was an important factor in this distribution of organizational power. Indeed, the analysis suggests that the internal political role of elite boards was their most significant social function. Study of the relationship between administrators, boards and physicians revealed the nature of this political role.

Administrators and Elite Boards

Administrators uniformly expressed regret and anxiety over the dissolution of the traditional elite boards. This response was related to the *social value* of the former board system for administrators. Much of this value lay in certain social attributes of board members and in the way in which administrators perceived these attributes.

Expertise

The technical expertise of elite board members was their most visible and often mentioned attribute. "In-house" engineers could be consulted on construction projects, and lawyers could supervise the development of a pension plan for employees. Administrators also appreciated the more generalized expertise of elite board members.

> (Board members are) . . . high calibre people who are accustomed to functioning as executives on a managerial level. These fellows, it is incredible, they can read something over in 30 seconds and cut right through the forest to the trees. (Admin R)

Administrators made frequent admiring references to the ability of their boards to "cut through the fat" and, particularly, to the time thus saved.

Administrators also valued elite trustees for their "social" expertise.

> The administrator might ask me to make thank-you speeches--to recognize some donation or what-have-you--or to represent the hospital at certain functions. (BM W)

Elite board members were used as public institutional representatives because they were experienced in such roles and because administrators felt they had the social stature necessary to perform such symbolic functions. Administrators appreciated being able to pass on certain public duties to board members both to ease their busy timetables and, sometimes, to avoid what they perceived to be uninteresting or unpleasant chores.

Respect for Managerial Autonomy

Administrators also appreciated elite boards because of their members' belief that they should not interfere with operational matters.

> The old elite board wanted to decide on the big matters, and they wanted me to do the spade work. I reported to the board, but they gave me freedom to run the place. (Admin A)

Elite board members were reluctant to infringe on their administrators' autonomy because they were sensitive to the need for managerial autonomy by virtue of their own executive status, and because they had neither the time nor (often) the inclination to become too involved in the running of the hospital. Because administrators valued their independence highly, they greatly appreciated the former boards' respect for managerial autonomy.

Predictability

Certain features of the social structure of elite boards permitted administrators to anticipate the attitudes and behaviour of members. For example, their homogeneous social characteristics, orderly and predictable succession practices, long terms of office, cohesion and loyalty among members, and shared norms regarding executive behaviour all allowed administrators to predict how their boards would react to their proposals or actions and thus considerably reduced the uncertainty inherent in the administrator-board relationship.

The administrators' ability to predict or anticipate board behaviour was also enhanced by the boards' internal social cohesion. Administrators could rely on their boards to control their own members.

> I also used them (board members) once when I had to contain a physician. I wasn't able to do it myself because he was the physician for several board members and he was so super to them and made house calls and all, but he knew damn all about medicine. He needed to be contained so *I went to some board members and put it to them and they arranged that their buddies didn't object.* (Admin E)

Furthermore, because administrators knew that most board members "leave things to the executive" or could be "persuaded" to concur with proposed decisions, they felt that they could treat the board as a unit and deal primarily with the president or a small executive group.

> My primary relationship is with the board chairman, I can't start confusing the issue and playing little

> games. He is responsible to the board. I let him take care of the others. (Admin R)

This strategy simplified administrative processes and also functioned to minimize the points of contact between boards and administrators, thus reducing the boards' potential for interference.

Administrators also made use of the social integration of their boards in a variety of other ways. For example, they included trustees in committees and ensured that the committees' proposals were presented to the board through these trustees themselves. Administrators found not only that the involvement of trustees "sensitized" them more favourably towards hospital problems but also that their presence on the committee lent credibility to its recommendations in the eyes of the rest of the board. Board members reasoned that the decision-making rationale must have been sound if a respected colleague was party to the deliberations.

Moral Support

A less tangible although not less significant function of elite boards was the moral support of the administrator. Administrators had few if any peers in the hospital with whom to confer, commiserate, or otherwise feel socially supported. Administrators often reported that their elite trustees gave them self-confidence and some sense of security.

> It's reassuring to have the support of the board, it's pretty nerve-wracking to make such big decisions by yourself. (Admin J)

> I feel very much better coming in here in the morning knowing that if there is some weighty matter that I can call one of the board members and get advice. (Admin A)

They also received simple, companionable support from board members,

> Once I came in when X (administrator) was most upset about some guy complaining, and I told him to just let him come in and shout his face off, what does it matter, you are doing the best you can and you can't please everyone. I had to cheer him up. (BM O)

and sought feedback and recognition from them, as is illustrated in this comment from an administrator whose board failed to provide such support,

> I would like them (board members) to be more concerned. . . . I would like them to recognize where we have made inroads. I'd like them to recognize what we do. (Admin J)

Perceived Impartiality

Administrators also valued the former elite boards because they perceived their members as being impartial. Administrators always emphasized the disinterest, the "outsider" status of elite boards.

> Outside, impersonal control, this is a good thing. The old boards didn't have any self-interest in being on the board. (Admin J)

Conflict of interest, however, was usually interpreted rather narrowly.

> Mr. X (board member) was a consulting engineer, and we kept urging him to put in a bid for our building project, but he never would. These board members had no conflicts of interest. (Admin J)

Most administrators perceived philanthropic interest to be the primary motivation behind the participation of elite board members. It must be noted, however, that it was not that elite boards actually had *no* "special interests" as administrators maintained here but that their interests were *compatible* with those of the administrators. That is, because elite boards did not represent an interest group that threatened the administrator in any way, they were seen as impartial and with no "horns to toot." This point will become clearer further on when the new boards are analyzed.

Political Role

Elite boards were also of significance to administrators for their political functions within and outside the hospital.

Control of the external environment. Elite boards were often perceived as able to enhance the administrators' ability to manage certain external organizational contingencies. For example, administrators often reported that their boards were useful to them in managing constraints imposed by the provincial government. In the first place, elite boards were a source of income which, however small in contrast to the over-

all budget, mitigated the hospital's financial dependency on the government.

> I feel we still have a certain freedom of action. I think it is the private input that gives us this freedom. If the government refuses us something then we know that we have some funds of our own to fall back on. (Admin C)

A "private" source of income enabled hospitals to get or do certain things that the government was not willing or able to pay for. For example, administrators sometimes reported that they used their "foundations"[1] to compete for high quality medical staff by supplementing regular government-regulated salaries scales or by offering such "perks" as research personnel, special equipment and so on. Private funds were also used for teaching and research, two areas explicitly not covered by the government but which were highly valued enterprises within university hospitals.

Regardless of how much financial independence a foundation might actually have provided, administrators appeared to feel a certain psychological freedom from having access to resources "outside the clutches of the government."

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[1]After the reorganization of Bill 65 many hospital administrators were fearful of leaving the hospitals' private money and endowments in the corporation (where it had previously been kept) because of the unpredictable composition of the board of the hospital centre and an apparent increase in the tendency of the government to regulate corporation affairs. Consequently these private funds were transferred to another legal body, call the "Foundation".

The financial significance of elite boards may also have played a more direct role in the hospitals' relationship with the government. Private money enabled the hospital to maintain some control over capital development, an area that has come almost entirely under state supervision. If hospitals had or could raise private funds, the government could often be persuaded to "match" the amount to finance certain projects or acquisitions. Indeed in the mid 1970's the government made moves to institutionalize such arrangements by making the acquisition of certain funds conditional upon being met with private funds, a gesture that only augmented the "value" of an elite board membership.

Access to private financial support was only one feature of elite boards that administrators saw as benefitting their relationship with the government. Some boards boasted a member who "specialized" in Quebec who had certain contacts in the government and or who occupied himself with hospital-government affairs and was involved in any negotiations or encounters between the hospital and provincial authorities. Respondents also mentioned projects that they perceived to have been launched by virtue of personal contacts between board members and the government.

> You never know when a person's contacts would come in handy. Someone may know someone in Quebec or Ottawa, lets say in research funding. It's not exactly exerting influence but more just saying 'I'll leave it up to you' and putting in a good word for somebody, or bringing an unanswered application to someone's attention. Little things like that though were often very helpful. (BM S)

Mention of political links such as these was made much less often by anglophone respondents than by their counterparts in francophone institutions. Probably, their history of political and cultural alienation from provincial affairs limited the ability of anglophones to perform such extra-organization functions.

There is some evidence, however, that the social stature of a hospital's board may have assisted the administrator in more subtle ways.

> In my own experience, to have influential people on the board has been invaluable. . . . The government was very aware that the board was made up of extremely influential people who were above question in ability. Now for the little civil servant, you can imagine he might be reticent to question the presisent of X. . . . It was obvious to me that the government had tremendous respect and confidence in these people and this was reflected in their attitudes to the hospital . . . if board members are well known, it influences the government because it is very bureaucratic; now, they aren't going to be intimidated by a nurse or a secretary are they? (Admin R)

Because I have little data from government authorities, I cannot tell whether they actually *were* influenced by the status of a hospital's board members. I was told on several occasions, however, that the Ministry was only too happy to have competent management in its institutions because they had neither the time nor the political desire to get directly involved in the management of individual hospitals. I also noted that board members (and generally the most socially prominent ones) were often, if not always, included in deliberations between hospitals and the

government. Auerbach's (1961) finding of a correlation between the prestige of a community agency's board and having financial requests given a "respectful hearing" may reflect this kind of influence process.

This function of elite boards relates to Perrow's discussion of organizational prestige as a factor in organization-environment relationships (Perrow, 1961). An organization, Perrow proposes, can limit its dependence on the environment by creating a favourable public image. Organizations may acquire prestige on the basis of "extrinsic" qualities that are only indirect indices of "intrinsic" qualities. In the case of hospitals, an elite board may have functioned as an "extrinsic referent" of hospital quality, thereby reducing the inclination of the government to intervene in organizational affairs. That is, the social stature of the board may have created a public image of competent management.

> I think the board is important in our relations with the province. Quebec has only to look at the board and they know it isn't necessary to interfere. With the president of the Interprovincial Bank on the board, they know that someone competent is overseeing the hospital's affairs. (Admin J)

Elite hospital boards performed additional extra-organizational functions for the hospital by virtue of their links with other leadership structures. The people who sat on hospital boards were also members of the boards of business and financial enterprises and of other public service institutions. Among 23 trustees on whom I could get information (through

direct questioning, Who's Who in Canada, and executive directories) 13 held or had held directorships on more than two other boards (business or social service) while 7 sat concurrently on over 3 other boards in addition to the hospital. The prevalence of shared or "interlocking" directorships has been frequently noted in the literature (see Sonquist and Koenig, 1974), particularly between major industrial and financial corporations. Closer to the health sector, Clement (1975) found that 13% of Canadian economic elites held board positions on both schools and hospitals. Kovner (1974a) found that 88% of his sample of American hospital trustees sat on at least two other industrial or public service boards of directors.

In addition to these formal connections with other leadership structures, hospital trustees had countless overlapping informal ties with a wide range of community influentials. Personal friendship, business associations, common club memberships and so on all increased the number of links between board members and other hospitals and community organizations.

This interconnectedness of community leaders appeared to have given hospitals with elite boards certain leverage in securing resources and managing external organizational constraints. For example, hospitals sometimes acquired financial support through overlapping leaderships.

> X (company) has given us lots of money--they built the Smith Pavillion in fact--The President was on the board here and was always very interested in the hospital and directed his company's philanthropic policies in our favour. (Admin J)

Or, the leadership connections of board members were used to solve certain organizational problems. One example of this comes from a hospital whose medical staff were putting pressure on the administration to "do something" about the increasing proportion of hospital beds taken up by chronically-ill patients who could not be discharged because of a shortage of nursing homes. At a meeting between the board executive and top medical staff, one board member reported:

> The subject came up--how to keep the place from filling up with chronics--if we could just get someone else to take them, this was the argument of the doctors. They thought that if we started from the top by contacting the chairman on the board of a smaller institution. . . . They felt it should be started at a presidential level, and I was appointed and I said fine as I already knew this man through business. So I called him up and said could you put on your board cap for a minute. Then I went down and spoke to him. (BM P)

Such informal manoeuvers functioned as a kind of "pre-test" for the negotiation of organizational projects or changes,

> When any kind of rationalization goes on it takes place at the board level first . . . the board would just find out if the general principle appeals. One board member might talk to another informally, and they would sound each other out. Then he'd go to the administrator and say, 'I heard from the X hospital that they might consider. . . .' (BM P)

and allowed administrators to avoid losing face by having their proposals turned down. (Moss et al., 1966, document the danger to administrators' authority of having their suggestions or recommendations questioned or rejected.)

Control of the Medical Staff. Not only did elite boards assist administrators in their relationships with the external environment, but they also played a role in the distribution of power *within* hospitals.

> The weak have to be defended. Some medical departments would be chased out by the more powerful ones if they weren't defended. This is where the board keeps a sort of political balance. (Admin R)

> If the staff know that the board isn't behind you, you're finished! (Admin F)

Particularly, elite boards were observed to increase the ability of administrators to control their medical staffs. Perrow (1963) found that the rise in power of a hospital administrator was achieved through the mobilization of the board behind him to exert control over the medical staff. Both Moss et al. (1966) and Gordon (1962) report that hospital administrators used their boards as leverage against the medical staff. My data also indicated that the position of administrators vis à vis the medical staff was buttressed by their elite boards, as illustrated in the following account of a meeting between the administrator, senior medical staff and the board executive.

> There was a chairman of a department (medical) who was really being recalcitrant. He needed to be brought into line. I had been eye-balling him to get into line, till finally X (board member) said 'Come on now So-and-So, get into line!' and it worked. But these meetings take place outside the hospital, and things are said that could never be said at a regular meeting. (Dr. D)

Administrators often observed that elite board members enhanced their authority and could "keep the doctors in line."

> I need a good board behind me. The administrator wouldn't have the authority, would he, just by himself. . . ? It's politically that counts. They (board members) are a match for some of these prima donnas (doctors). (Admin R)

But how did elite boards influence the medical staff, and how was this influence mobilized by administrators? Although mention is often made in the literature about the "control" functions of boards, the dynamics of the process are not spelled out. Belknap and Steinle (1963) found that organizational success in their sample of hospitals rested largely on the elite composition of the board and on the cooperation of the medical staff. They did not elaborate on how these two factors might be related. I now turn to an examination of the nature of the relationship between boards and physicians.

Physicians and Elite Boards

The data suggest that doctors share certain general perceptions of the board and that board members share certain beliefs about the medical staff.

Elite board members had a relatively uniform conception of physicians. Generally, they saw them as talented men of science with unquestionable expertise, who, somewhat like children, had little appreciation or understanding of the "real world".

> I try to explain to them (doctors) that there has to be an administration. Doctors can't run these things. They are notoriously bad at money matters, of course. They just ask for something and can't understand why they can't have it. (BM O)

Board members often took a detached (and sometimes bemused) view of medical life as a professional battleground.

> But you know, none of the departments trusts each other. They all have their own empires. (BM B)

But, they also recognized some of the rewards and incentives of the medical world,

> Doctors care about money, but they have this old pride of craft, they get their jollies out of recognition by their peers, that's what's the driving force behind them. (BM W)

and felt the need to adapt their administrative approach to these characteristics.

> There is a terrible medical establishment too. They can be quite a handful. You can't just tell them what to do like in business. . . . (BM O)

Physicians, on the other hand, also shared somewhat stereotypical views of their trustees. Here, however, I must distinguish between the average junior or administratively uninvolved physician and the senior medical staff. The former, largely by virtue of their preoccupation with clinical matters and their distance from organizational decision-making, tended to have only vague ideas about the board and its function. When asked about "the board" they first thought of the medical board which

was the executive body of the professional staff. Many believed that the board was comprised of "big wigs" or "charity types" who were essentially inconsequential to themselves.

> I don't think the board matters at all. Certainly not at a university teaching hospital. There are just so many people involved, the university, the government planning commissions. . . . I don't even know who is on our board, which goes to show how little they concern me. (Dr A)

Many senior medical staff, however (chiefs of departments, medical board executives and committee members), had a somewhat different relationship to the board of directors. These physicians varied in the degree of organizational importance they accorded their boards of directors but most clearly acknowledged their *authority*. That is, according to Fox's definition (Fox, 1971) of "authority" as the perceived legitimacy of a superior-subordinate relationship, *physicians acknowledged and accepted the right and the appropriateness of these boards to make decisions in certain areas of hospital policy*. I now look at some of the bases of the boards' authority vis à vis the medical staff.

Bases of Board Authority over Physicians

Legally, boards have ultimate authority in hospitals. Their administrative roles are set out in the by-laws of the institutions, usually in such general and inclusive terms as ". . . to see to the well-being and proper management of the hospital." In practice, the boards' responsibilities were vaguely and inconsistently defined by the administration and

the medical staff (Moss et al., 1966; Georgopoulos and Mann, 1962; Arnold et al., 1971). Ambiguity in the bureaucratic component of the boards' authority put emphasis on other sources of authority and on processes of informal interaction between power groups.

Physicians recognized as legitimate the authority of elite boards because of their instrumental "value" (their usefulness on a pragmatic level) and their perceived attributes (nature or quality of board performance).

Instrumental value. Elite boards provided several "resources" and "services" which were of use to physicians. The ability of boards to provide financial resources was their most visible attribute.

> I must say, the old board was remarkably receptive. There weren't many who couldn't get what they wanted from the board. . . . (Dr E)

The boards' financial role gave them certain control over hospital matters. For example, because of their access to funds, board members tended to be included in most hospital committees, which were the loci of most administrative decision-making. Although membership on such committees did not necessarily give board members direct power, it at least gave them the opportunity to become knowledgeable in hospital affairs and, to communicate directly with hospital staff, both of which have been identified as important in the ability of boards exert organizational control (Moss et al., 1966; Harkness et al., 1963;

Georgeopoulos and Mann, 1962).

Physicians also acknowledged their board's role in the acquisition of non-financial "resources," such as, for example, its "help" in negotiating arrangements with other institutions, or its ability to secure political "favours" from the government.

> These guys (old board members) could swing things for the hospital. They always seemed to know somebody or have a contact in the right place that gave the hospital a bit of a break. (Dr F)

An additional advantage of elite boards in the eyes of physicians lay in their administrative skills. Doctors felt that because these board members were executives and managers in their outside occupations, they had much to contribute to the administrative operations of the hospital. Physicians recognized the utility of a "well-run show" (as one doctor put it) to their own professional practices.

> Somebody has to run the place. It's critical. You can't just have a bunch of doctors running around treating patients without somebody making the whole system fit together. It makes a huge difference to how doctors can practice if the place is well run. They (elites) know how to do it. They're used to running their own businesses. (Dr K)

A further instrumental value of elite boards for some physicians was access to an upper class clientele. Although the subject was rarely discussed openly, the data provided some evidence for this possibility.

> I first met him (board member) through board committee work . . . he has since become a patient of mine, and his family too. (Dr K)

> I don't like to have physicians on the board. There is always suspicion from the other MD's that they are there just to get themselves some wealthy patients. (Admin E)

Among six board members with whom I had close enough rapport to question closely on such matters, all reported that they or a member of their family had consulted or went regularly to a senior physician in the hospital on whose boards they sat.

It has often been observed that physicians and other professionals prefer an upper class clientele for reasons of professional and personal satisfaction (e.g., Walsh and Elling, 1968; Willie, 1960). Elite patients were often seen as conferring prestige by association on the professional treating them, and even sometimes provided more direct "rewards".

> I might have a patient who I know represents a lot of money, and perhaps she is very satisfied she will say 'I've been very pleased and I'd like to leave something to your department and to the hospital in recognition of this . . .' so I go and talk about it with her and usually this is in conjunction with a member of the board. (Dr D)

Not only did physicians know board members as patients, but there were also extensive social ties between them. Although physicians did not appear to be part of such wide social networks as were businessmen and other professionals, six out of eight doctors interviewed reported that certain board members on the former boards were their personal friends or that

they saw them at parties or clubs. The existence of such physician-board ties was also supported by data from board members who were asked to indicate if they were personal friends with or knew well enough to "stop and chat if you met on the street" any of five senior physicians in their hospitals (the chiefs of Surgery, Medicine, Obstetrics and Gynecology, Psychiatry, and the chairman of the Medical Board). Of six board members questioned, one said he knew none, two said they knew one, two others knew two, and one knew four of these top doctors.

Social links such as these were undoubtedly related to the common upper class backgrounds of board members and physicians (particularly in the past, I suspect) and to the small size of this upper class community in English-speaking Quebec.

The instrumental value of doctor-patient relationships and personal acquaintance between board members and physicians lay in the "access to the top" that it gave the latter.

> My own doctor at X (hospital) always complains to me when I go to see him about lack of space, or his need for something new or whatever. (BM M)

> (Do you ever see board members outside the hospital?) Very much so. I see many of them. Yes, we talk about the hospital, it is dear to the hearts of all of us, isn't it?
> (What kinds of things do you discuss?)
> Well, do you know X (BM)? Well, he might come up to me and say 'What's all this I hear about radiology?' or he would ask me, say, about the function of some unit and say 'What's going on there?' Or Y (BM) would come and when I was trying to find a new chief of department and was having difficulty, he'd say 'What's the hold up?' and I'd tell him that it's just not that easy, people aren't all that willing to come to

> Quebec . . . or he'd say 'I met up with Such-and-Such from your department, I played tennis with him and he seems a nice guy--what about him?' This sort of thing. (Dr D)

Direct access to the board meant that physicians could, if they wished, bypass the administrator who, as I have described earlier, generally controlled communications up to and down from the board (this point will be discussed more later). Doctors also felt that their ability to "talk things over" directly and informally with board members resulted in "more action" as one doctor described it. Harkness et al. also reported that the physicians and board members in their study met at clubs and each others' houses and "found the informal situation a better vehicle for problem resolution and general communication than the formality of a meeting" (1963:227).

Perceived attributes. The willingness of physicians to acknowledge the authority of the former elite boards was not only related to their instrumental usefulness, however. It was also fostered by the fact that physicians perceived these boards to have certain intrinsic attributes which they liked and which they found compatible with their own values and interests.

The first of these perceived attributes was *prestige*. Although senior physicians were often themselves of high social status and accustomed to dominant professional roles (Friedson, 1972) many nonetheless appeared impressed by the social stature of certain board members.

> But you know, there was a bit of an aura when a Johnson or a whosiwhats was on the board, they were pretty important people after all. (Dr K)

> I find it very hard to stand up to someone like X (elite BM), I'm awed when we have a meeting dealing with finance. It's a big deal, and he's an important individual. (Dr C)

Physicians' respect of and deference towards elite board members in general was related to the nature of board members' *expertise*. Business and administration were subjects with which few physicians were familiar but which they saw as having obvious and direct relevance to the hospital. Most importantly, they were subjects which physicians generally conceded to be outside their professional jurisdiction. Administrative expertise did not threaten the clinical autonomy of physicians as might disciplines closer to medical practice. It is interesting to note that while administrators and board members spoke mostly of the wisdom or general experience of elite members, physicians referred more often to specific skills.

> They have an expertise, a knowledge the board can't do without. The place would fall apart without them. They know about finances about building, about planning. I am on the building committee and we have an engineer on there who knows what contractors to engage and so on. How could we know those things? (Dr B)

It is possible that recognition of a more generalized competence might have legitimated greater board involvement than the medical staff desired.

Physician acceptance of elite boards was also promoted by the way in which members' presented themselves, their *style* of performance.

> They are so impressive. They have always done their homework. . . . Mr. X doesn't really know the internal situation, but he doesn't miss a trick, he is very sharp. (Dr G)

> Some of them are impressive sorts of people . . . people who say OK this is this and this is that and I want a report back in one week. Sharpies, aggressive people. (Dr K)

Physicians often linked the mannerisms of elite trustees to efficiency and authoritativeness in this way. However, even in the absence of such visible displays, board members were imputed competence on the basis of their outside positions.

> You sort of figure that if he is a president of a bank then he must be somebody. He can't be a dodo. (Dr K)

A further important factor in physician support of elite boards was the latters' belief in *non-interference*. As has also been reported in the literature (Kovner, 1974b; Harkness et al., 1963; Gordon, 1961, 1962), elite trustees were deferential towards physicians, did not feel qualified to judge medical matters and trusted the medical profession to regulate themselves. Only occasionally could physicians recall an instance of board members interfering in clinical matters.

Like administrators, the medical staff also valued what they perceived to be the *impartiality* of elite board members.

Elite boards were considered disinterested because they did not have any "conflict of interests" that were visible or relevant to physicians: they did not represent any competing professional interests and came from outside enterprises which physicians perceived to have no vested interests in the hospital.

> The board plays a strong mediating role between the different groups. . . . They can go to the staff and say, look, here we are going broke, we've got to do something, let me help, I can preside, I am neutral, an outsider. (Dr C)

Partiality was acceptable, of course, if it favoured the position of the medical staff. Many physicians valued elite board members for their *empathy*, their ability to "understand" the medical world, to sympathize with the doctors' perspective. This capacity for empathy was maximized in elite boards by the similar social backgrounds of trustees and physicians, and by the direct contact and communication made possible by the friendship and doctor-patient ties between them. There was, of course, disagreement between them, but the "value cleavage" that is frequently presumed to exist between them in the literature is not empirically substantiated. Indeed Georgopoulos and Mann (1962) found considerable value consensus when they examined hospital board-staff relationships in detail. My research also suggests that elite board members and senior medical staff held congruent "definitions of the situation". Both groups, for example, had common long-term institutional interests in the hospital. The technical repute of the hospital was

important to the medical staff, whose professional careers are directly tied to organizational esteem, and to trustees, whose social identification was also, although less explicitly, affected by organizational performance. In the past, for example, both groups have been oriented towards development of the technical dimension of hospital care. The present vast array of costly and complex equipment and research facilities testify to their collaboration. Such development was tangible and quantifiable "evidence" of organizational "success" (in contrast to the elusive and still unmanageable measurement of such indicators as improved health, or effective medical care) which was consistent with the elite board's need for visible philanthropic output (necessary to the maintenance of financial patronage and their own reputations) and with the physicians' perceived need for technological hardware and services. The organizational autonomy of the hospital and associated principles of "free enterprise" were other institutional objectives shared by many elite board members and hospital physicians.

In sum, then, the bases of board authority vis à vis the medical staff lay in the instrumental value of board member contributions and in certain qualities with which they were attributed. Elite boards were "useful" because they could furnish financial and other resources, they could lead to the acquisition of prestigious patients, they could contribute important administrative skills, and they ensured an accessible "ear at

the top." Their valued attributes included social prestige, a non-threatening expertise, deference to professionalism and clinical autonomy, and empathy for the doctor's perspective. The following quotation illustrates the cooperative, non-competitive terms in which many physicians viewed their boards.

> The board's role is to give advice rather than to direct. They give advice and generally just help out in all areas other than those that relate to patient care. They don't often make decisions on their own, they mainly just help out. (Dr D)

"Helping out" and non-directive advice-giving, however, did not come gratuitously. Physicians were expected to offer certain compliance in return for the resources, services and support they received from their boards.

> You know where they (doctors) get their kicks. It's a trade-off: if they don't cooperate with you, you don't cooperate with them! (BM W)

> They (board) basically left us alone, but they gave us help when we asked for it. And we tried to go along with them, really, and we put up with a certain amount of organizational flak because they wanted it. We scratched each others backs I guess you'd say. (Dr K)

Thus, the authority of the boards vis à vis physicians was as much a process of *exchange* as it was a matter of legitimation. Boards exerted certain control over the medical staff both because the latter--for the reasons discussed in this section--perceived them to have the "right" to have such control, and because the boards had resources or services to offer in return for cooperation.

Managing the Social Functions of Elite Boards

This chapter has been arguing that the organizational control of administrators was enhanced by certain attributes of elite boards and by their authority over the medical staff. Such an advantageous position, however, could not be taken for granted; it had to be carefully managed.

Involvement Versus Interference

Consider, first of all, the administrators' relationships to their boards. The very forces that tended to increase the administrators' power could, if not constantly orchestrated, also undermine it. For example, if a board was to provide meaningful guidance, its members had to be kept adequately informed on and involved in hospital affairs. In my study and throughout the literature administrators maintained that the more involved their board members were, the more useful they were administratively. At the same time, however, too much involvement became "interference" and reduced the administrators' independence. Administrators thus had to carefully manage the degree and nature of their board's "involvement" to maximize the advantages without sacrificing control.

Another important element in "making the best of the board", as one administrator put it, was the management of trust. In my data and in the literature (e.g. Moss et al., 1966; Gordon, 1961) there is ample evidence that the more a hospital board

trusts the administrator, the less closely he is supervised.

> We have a pretty good reputation as a hospital. The people on the board realize that we are trying our best . . . and that their money is basically in good hands. *They figure we are running the place alright, so they leave us alone.* (Admin J)

In order to secure their independence from the board, then, administrators needed to create a relationship of trust with the board. Although, obviously, this process was very intricate, there were certain strategies that administrators used to sustain the confidence of the board. For example, administrators recognized the value of precedent: success breeds success while failure breeds distrust. For this reason, examples of administrators having proposals rejected by the board are rare. Administrators referred to the "feel" they developed for what would be acceptable to the board, and they continuously pre-tested ideas and negotiated consensus to avoid the costs of being turned down. Perceiving that they usually concurred with the administrator's judgment, boards tended increasingly to approve proposals without much scrutiny. Such a process probably contributed to LeRocker and Howard's (1960) finding that administrators became increasingly independent from their boards as time went on. The number of decisions made by boards in hospitals where the administrator had worked less than ten years was twice as great as that made by boards with administrators with more than ten years experience.

Information Control

The relationship between elite boards and physicians may have contributed to the administrators' organizational control, but it also could detract from it. The issue of information control illustrates this problem.

As I discussed earlier, the administrators' strategic location in the hospital gave them considerable control over the vertical flow of information between the hospital staff and the board. By filtering the information that reached the board, administrators could influence how board members perceived, interpreted and responded to their proposals. Similarly, administrators could "interpret" the board to the rest of the hospital and ward off pressures or vie for time with "I'll have to check with the board first." In a study of psychiatric hospital administrators Hawkes has observed:

> It is safe to generalize that to the extent that the administrator allows or encourages communication between the two groups (board and doctors) to that extent he loses power and control both inside and outside of the hospital organization. (1961:104)

The social links between physicians and elite boards however, gave the former access to the board without going through the administrator.

> The senior doctors play golf with the trustees, and the administrator stays at home because he's not usually of that crowd, and that's why he may lose out. (Admin E)

Physicians also had direct access to board members through the

various board committees. Thus, some of the very features of elite boards that increased the board's control over the medical staff could also be used to bypass the administrators, reduce their control over information, and thence diminish their organizational power. Administrators were aware of this danger at the same time as they recognized the value of such close board-doctor contact. Administrators tried to manage the situation in order to garner the advantages with the least loss of personal control. In the hospitals I studied detour around the administrator on matters of controversy or consequence generally only occurred when relationships between administrators and staff were hostile.

> We would go to X (Admin) and it would disappear up and something completely different came back down. It was very demoralizing until we realized we had to go directly to the board. It's now that we need the board . . . it's the only way you can control your own destiny. The only access we have is to appeal to the board against the administration . . . we've gone over X's head and the board of directors has recognized our problem and is supporting us. The board is very potent you know. But if the administration gets control of the board, you have no one above the board you can appeal to. (Dr K)

The issues of involvement/interference and of information control suggest that the social functions of elite boards were at once advantageous and potentially detrimental to administrators and were subject to continuous negotiation and exchange as the major decision-makers in the hospital manoeuvered for organizational control.

Summary

This chapter has argued that elite boards fulfilled certain social and political functions within hospitals. Administrators valued these boards because they saw them as furnishing valuable administrative expertise, because their behaviour was predictable and they had internal control over their members, because they gave administrators moral support, because they allowed administrators considerable managerial autonomy, and because they had certain control over the medical staff by virtue of their perceived authority.

An important point to underline in this analysis is that the social functions of elite boards arose less from any *objective* qualities of board members as from the way in which board members were *perceived* by administrators and physicians. Elite boards were seen as useful and their organizational power considered legitimate, but both "usefulness" and "legitimacy" are inherently social concepts. Thus, for example, the boards' expertise was an important factor in their authority less because it was an intrinsically valuable organizational asset than because it was compatible with the expertise of the doctors. Similarly, both administrators and boards perceived elite board members as being impartial not because they were in fact disinterested but because their interest in hospital affairs was either not recognized or was seen as consistent with those of administrators and physicians.

Underlying the perceived attributes of elite boards and the social and political functions that were associated with these attributes is the issue of *power*. Elite boards influenced the distribution of power between administrators, boards, and physicians. Although this political function had to be "managed", it generally tended to enhance the administrators position of control, principally by reducing some of the uncertainties of the board-administrator relationship and by increasing their ability to handle the medical staff.

PART III

THE OUTCOME OF BOARD REORGANIZATION

Part II has described the nature and function of the elite hospital board structure that existed before Bill 65. Part III uses this analysis as the basis for examining the impact of reorganization. It includes three chapters. Chapter VI studies the management of social change. Reorganization was not achieved without resistance and political maneuvering among those who sought to acquire control through hospital boards and those who sought to retain the status quo. This chapter looks at the process of board assembly and at strategies of control. Chapter VII considers some of the social consequences of democratization. How did reorganization affect the nature of board work and the distribution of power within the hospitals' administrative "triangles"? Chapter VIII illustrates the analysis through brief case studies of how three "democratized" boards handled situations of organizational difficulty and conflict.

CHAPTER VI

THE MANAGEMENT OF CHANGE

Bill 65 was enacted in the last days of 1971, becoming Chapter 48 of the Statutes of Quebec. Regulations published in the fall of 1972 laid out the details of how the new representative hospital boards were to be assembled. In June 1973 the old boards were dissolved and over the next month the new members took office.

Hospital administrators were very anxious about the outcome of reorganization because, as I have discussed earlier, they had considerable organizational and social "stakes" in the existing board composition. Moreover, as Lipsky and Lounds have written, administrators have "prospered through the practice of divorcing politics from administration" (Lipsky and Lounds, 1976, p. 88). Consequently, once the legislation was passed, hospital administrators actively attempted to "manage" the construction of their new boards by shaping them as much as possible to their own advantage. Close collaborators in this endeavour were members of the old elite boards, particularly the former executives.

At the same time, however, two other groups had an interest in the process of democratization: the government and organized labour. The former had a vested political interest in the outcome of reorganization and wanted to introduce change

without incurring undue institutional disorganization. The latter saw reorganization as a potential access to power for "le monde ordinaire."

This chapter describes how these various groups, particularly the administrators and "old" board members, attempted to manage the process of change. First, they tried to control the assembly of the new boards, to influence who would or would not be appointed or elected. Secondly, once the new membership was in place, they tried to control its behaviour, to manage its involvement in hospital administration.

Assembly of the New Boards

The assembly of the new boards was marked by active political engineering,

> A lot of people worked overtime to get the right people on the board. It's all engineered to get the right people. (BM O)

> On a fait pas mal d'efforts pour mettre nos gars là-haut. Il nous a fallu user de stratégie! (union organizer)

> Le gouvernement ne cherche pas à nuire aux hôpitaux, il faut quand même un peu de continuité, alors on a choisi avec soin . . . . (government official)

But where and how did manoeuvering take place? Consider once again the official structure of the new boards.

Number Of Seats	Representing
4	The hospital Corporation
2	Patients of the hospital
2	Socio-economic groups in the community
1	Non-professionals in the hospital
1	Professionals in the hospital
1	Doctors in the hospital
1	University (if a teaching hospital)
1	Interns and residents (if a teaching hospital)
1	Local community clinics

Considering these positions from the bottom up, we note first that at the time of reorganization there were no anglophone local clinics to designate representatives to the board, so this slot remained unoccupied. The University appointed faculty members or other individuals to represent them. Because these appointments were generally individuals who were on or closely connected with the former boards, administrators felt they could rely on a "good" nomination and made relatively little effort to influence the University appointments. The interns and residents slot was filled with difficulty because the term of office started just as students were changing rotations, and because the students had low organizational commitment, were preoccupied with medical training, and had extremely busy schedules. Some effort was made in several hospitals to recruit junior medical staff for this position to "avoid getting a bad egg," but generally administrators did little more than prod senior residents to find a candidate and were not particularly upset when, as was often the case, their delegate failed to appear

at meetings.

Election of a representative of the physicians did not elicit much concern in most of the hospitals I studied. First, physician representation was not new; most boards had already included a delegate from the medical staff. The physicians themselves did not express much interest, primarily, it would seem, because they had always had alternative routes to the board that they perceived to be more important than formal representation.

> We used to have a representative on the board. But he didn't do very much. Reported on what was happening medically I guess. We didn't really need a representative there. X (admin) presented our case well and kept us well informed. And we knew board members too and saw them around. (Dr G)

The representative of the hospital's professional staff was elected at a meeting of all those qualifying as "professional" as listed in the regulations (nurses, physiotherapists, social workers and so on). Although it varied in different hospitals, awareness of and interest in board reorganization was low among this group of people, and election turnouts were generally small. Very often a nurse was elected, partly because nurses were the most numerous and were more likely than other groups to have previously sat on board committees and to have been approached by the administration to run for election.

More activity characterized the election of the representative of the non-professional staff of the hospitals. The union affiliation of these employees invited and facilitated

the involvement of outside labour organizers, particularly in French-speaking hospitals, because of the greater unionization of employees and their concentration in a single syndicate. Union-supported candidates were proposed in most English-speaking hospitals, although often with little involvement of the hospital employees in general.

Two seats were assigned to representatives of the major socio-economic groups in the community. Nobody had a clear or consistent understanding of who these members were meant to be or how they were to be selected. The general idea was that community organizations, such as the local Board of Trade, or the Kiwanis club would submit the names of candidates to the Ministry who would then choose from among those proposed. The openness of this category invited the involvement of the administrators, the unions and the government.

The "patient" or "user" positions were also "up for grabs" because anyone who had used the hospital's services within the previous three years had the right to stand for election and vote. Elections, held according to published regulations, were announced in local newspapers and held on a certain date usually in the hospital auditorium. Candidates stood up and made short speeches and then voting took place by ballot. Former elite board members who qualified as "patients" were "run" by the administration against "patients" recruited by the union. The various interest groups tried to get as many supporters as possible to come and vote for their candidates. Administrators,

for example, urged their hospital's financial "governors" to attend the elections, and at least one hospital administration arranged for a bus to bring members of the religious order traditionally associated with the hospital to the polling station. Despite this sort of active recruitment of voters, however, only 14% of the eligible electorate actually voted (Montreal Star, 1974). In this first set of elections, however, the required quorum of 100 was met in most hospitals and certain institutions had over 1000 individuals pass through their polls. Public interest, however, declined substantially in subsequent election years (Couture and Gravel, 1977). For example, in the 1974 patient elections 15 out of 80 Montreal hospitals failed to get a quorum and had their representatives appointed by the government.

The final four seats were alloted to the hospital Corporation, which, under the new legislation, retained ownership of the hospital's physical facilities and consisted of the former financial patrons of the hospital (which included all the previous board members) and any member of the public who wanted to "join" by making a specified contribution to the hospital. (There were, in fact, few if any of the latter.) The Corporation called its members to a meeting to formally "elect" four persons to sit on the Hospital Centre board. These individuals were selected by and from among the chief executives of the just-dissolved board of directors.

The filling of certain positions evoked considerable

anxiety on behalf of the major groups with an interest in reorganization. The involvement of the various constituencies depended on their ability to influence the selection of candidates and on their perception of threat. Thus, for example, no one expressed much interest in or concern over the representative of the university. The government and the labour union had little or no ability to influence the selection of such a candidate, while hospital administrators and old board members felt generally confident that the university would make an appointment that was satisfactory to them. The degree of constituency organization was a further factor influencing the intensity of the "politicking" over certain board positions. Organized communities were less accessible to outside intervention (e.g. the physicians' professional organization in the hospital, or the hospitals' professional staff), while an ambiguous and unstructured constituency invited intervention (e.g. "patients" and "socio-economic" groups).

Strategies of Control

Although political manoeuvering is the very stuff of the democratic process, most of the individuals and groups I studied acknowledged that there was such a thing as the "spirit of the law." Because reorganization centred around the principle of participation, a "motherhood" issue, participants often expressed a sense of guilt about "tampering" too much with the assembly process and attempted to justify their involvement in the

selection of board members. The most common rationalization in the anglophone hospitals I studied was to claim moral exemption from the law.

> I can see what the government are trying to do. Many hospitals, particularly smaller community hospitals have been run by the doctors or by one administrator. The legislation is aimed at these places, not at hospitals like ours. If all hospitals were run like the X (own hospital) there would be no need for change. But the government wants to standardize, and they have to legislate for the 249 (hospitals) and not for the few. (BM K)

Both board members and administrators observed that their hospitals were not "typical," and were thus somehow outside the intent of the law. Another justification offered was the need for knowledge and expertise.

> If there were no control of who got on the board, if some effort were not made to get good people on the board, there would be great gaps in the board's knowledge. The board would be unworkable . . . we have worked hard to get certain people on the board, so that we end up with some expertise. (BM B)

The sacrosanct quality of knowledge and expertise was used here in much the same way as it was used to justify the former elite board system as seen in Chapter IV.

Intervention was also legitimized by claims of the prior organized involvement of competing interests. Administrators and former board members reported that they felt "obliged" to be more "active" when they discovered that the unions were "putting up their boys" for election. Ministry officials and union organizers also defended their activities in terms of

being compelled by competing campaigns.

In sum, most participants felt somewhat uncomfortable about becoming actively involved in the assembly process. Incumbent authorities eased their discomfort by interpreting their involvement as necessary to "preserving the high quality of care," while those attempting to change the existing distribution of power claimed that their action was necessary to counter the oligarchic strategies of those already in control.

But what was the nature of this "involvement"? What strategies of control were used to manage the assembly process? The law's regulations made hospital administrators responsible for most of the organizational details of reorganization: notifying the hospital staff and the public of their representation and voting privileges, collecting and publicizing candidate nominations, chairing of the "patient" and other elections. These *formal* responsibilities, however, gave them certain *informal* control over the outcome of the assembly process. The following three strategies illustrate the administrators' capacity for influencing the new composition of their boards.

Information control. Despite newspaper coverage and bulletin announcements, the general public and many hospital personnel knew little about board reorganization and even less about organizational details. In contrast, administrators had usually reviewed the legislation carefully and received numerous memoranda on the subject from the government. This superior access to information gave administrators considerable power as they

could control the information they shared. One example was the management of certain ambiguous or controversial aspects of the legislation. Because of their relatively exclusive access to sources of information, administrators could interpret regulations to their advantage without much fear of being challenged. The data are not lacking in illustrations of this form of control.

> At first Mr. X (administrator) told us that only those belonging to the professional corporation could vote. Then he realized that that would mean the rest of us would be in with the non-professionals, and that he didn't want because he was trying to get his finance director in there. So suddenly another government directive arrives . . . and we are told that 'professionals' now include all those who do the work of professionals. (hospital social worker)

Administrators also influenced reorganization by being selective about *with whom* they shared information. In preparation for the patient elections, for example, several administrators arranged for patients to be telephoned and urged to come and vote. The "patients," however, were selected from among the hospital's governors and financial patrons. In other words, only "friends" of the hospital were notified, people the administration could rely upon to vote the way it wanted. A similar kind of selective notification sometimes occurred before the elections of other board members.

> They posted it (election notice) on the board outside the cafeteria. Many of the girls don't go down there to eat, though, and anyway, no one ever looks at that board, you just go straight in for lunch! (physiotherapist)

In another institution, most of whose patients were in wheelchairs, the announcement of the user election was placed so high on the bulletin board that it could not be read.

Personal recruitment of candidates. Administrators also influenced the outcome of reorganization by personally soliciting the candidatures of individuals on whom they felt they could rely.

> I would never have proposed myself, but Mr. X (administrator) asked me. I was in his office one day and he mentioned something about running in the election. I said 'What's all this about'? I'd never heard about it before. So I figured, why not? (NBM,[1] nurse representing hospital professionals)

Administrators engaged in this kind of recruitment particularly for the loosely or unorganized constituencies of patients and hospital employees. Many of the individuals approached appeared to be flattered and stimulated to participate where, unprompted, they would probably never have taken the initiative themselves. These candidates benefitted from the administrators' endorsement and were given help in organizing a campaign and securing support. From the administrators' point of view, this tactic not only reduced the risk and uncertainty of the elections to themselves but also created with the successful candidates a certain obligation or "debt" which they could tap in their later relationships with the new board.

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[1]Recall that "NBM" = new board member as opposed to the former elite members.

Extensive personal recruitment also characterized the nomination of candidates from socio-economic groups in the community. Seldom did local organizations propose their own candidates without prior solicitation from hospital managements. Couture and Gravel (1977) found that 8 out of the 12 socio-economic representatives on the boards they studied in the Quebec region had been solicited by hospital administrators. Indeed, the authors concluded that "La partie patronale de ces établissements a dominé ce processus encore plus qu'elle ne l'a fait dans le cas des élections des usagers" (1977:211). Because of this prior selection process, the socio-economic groups that proposed candidates seldom included such groups as employee or worker organizations, citizens groups, or other organizations that might potentially have different points of view from the management.

Procedural manipulation. By virtue of their superior access to government information and of their officially delegated administrative responsibilities, administrators could also exert control over board assembly by manipulating certain procedures to their own advantage. For example, deadlines for the filing of nomination papers were on occasion overlooked in the case of "acceptable" candidates, or as happened in one hospital, the nomination forms of an "undesirable" candidate were mysteriously "lost." In contrast, strict adherence to regulations was also a control tactic. In one institution where the patients were all out-patients, election turnout was limited by the adminis-

trator's refusal to get permission to open the polls during the day rather than in the evening as stipulated by law. Elsewhere, an administrator, who was opposed to several of the "patient" candidates up for election, declared "no quorum" after the exact alloted waiting time even though several voters had scurried out to round up the two missing individuals from among the hospital's in-patients.

Mobilization of the elite community. Much of the administrators' ability to control information and to find and support "good" candidates depended upon the social cohesion and organization of their former elite boards and of the broader upper class community to which they belonged. For example, in some hospitals, the selective notification of the patient population was carried out through the Women's Auxillary. The women of this volunteer hospital organization, usually relatives and friends of the board or the medical staff, were approached by the former board executive and the administrator to "once again put your time and organization to work for the good of the hospital." Members who qualified as patients were telephoned and asked to attend the elections and vote for the administration's candidates. In one hospital the Auxillary went through lists of hospital admissions and telephoned those they knew or felt they could persuade to vote. In others, letters were sent out to friends of the hospital--Auxillary and Corporation members, financial patrons and so on--informing them of reorganization and soliciting their support. In one circular, for example, a

message from the board's president said:

> We deem it vital to the maintenance of the quality, direction and . . . of this institution that the nominees Mr X and Mr Y be elected . . . these two men represent the philosophy of the administration . . . we need you, your vote and your support. . . .

At the first patients' election, the elite community "turned out in droves" as one administrator described it. At two hospitals whose elections I attended the electorate was clearly predominantly "friends" of the hospital. Many people seemed to know each other. From brief interviews and overheard conversations, I observed that many voters had only the vaguest understanding of what was happening, and had come only because of perceived social obligation. A brief snatch of conversation illustrates,

> A: Hello! Nice to see you. How's George. . . ? What's happening here? Who am I meant to vote for?
>
> B: Isn't it dreadful. I just can't see how these people can be expected to run a multi-million dollar organization without business experience.
>
> A: But isn't there something special going on? Aren't they afraid someone will get on who they don't want? I thought there was something urgent about us all coming out on a Sunday! The Smiths came in from the country for it.

The advantages to administrators of a loyal and organized body of supporters was evident in those instances where no such association existed or was not, for whatever reason, mobilized.

Other interest groups--such as unions, or in one case, a group of active nurses--were able to get candidates elected that the administrators did not expect or like.

The social organization of the board and its links to the elite community were also important in the administrators' ability to recruit candidates for the new boards. Former members sometimes felt hesitant about the risks of an election and of participation on a democratized board, but some were encouraged to run by feelings of group allegiance.

> It was my decision (to run for election), but there was sort of a we-feeling, like you had to run out of a sense of duty. It was us versus the government; you sort of had to run. You know what I mean. It was as if we had to stick together. (BM K)

Political balancing. Control over the make-up of the new boards was also evident in the process of appointing the representatives of the so-called "socio-economic groups." Because few if any community organizations outside the health and welfare field were aware of their rights to representation, the initiative for the nomination of candidates most often did not originate with the "socio-economic" groups themselves. The process was open to manipulation both in the solicitation of nominations from community organizations and in the final selection of representatives from among those nominated.

Both the nominee and the sponsoring organization could be strategically selected. Usually the administration or other interested group would think of a candidate that they liked

and who had characteristics of which they felt the government would approve. Then, they would pick out what they perceived to be an appropriate or influential community organization to sponsor the person they had chosen. The following quotation from a hospital social worker illustrates.

> The union is putting up X for socio-economics. We tried to think and we thought of Y . . . he has been very active, but he has just retired, which might not be so good, but then X is no spring chicken either. Y is very representative. . . . We had thought first of the Family Planning Agency and then we figured that maybe they wouldn't go in for that in Quebec, what with abortion and the Pill and all . . . so we went to this respectable old people's home and got them to sign the nomination forms.

An interesting English-French difference appeared in my data in relation to the appointment of the "socio-economic" board members. Anglophone respondents, although they recognized the discretionary role of the government in the selection of these board members, tended to perceive selection criteria as centered around issues of community representation, as is shown in the exerpt above. In contrast, the francophones I interviewed more often saw this board position as a direct political appointment.

> La réorganization est une action tout à fait politique. On a voulu remplacer les gars de l'Union Nationale par des Libéraux. Le gouvernement veut avoir un plus grand contrôle sur les institutions publiques en choisissant ceux qui étaient élus comme représentants des groupes socio-économiques. (union organizer)

The validity of such an opinion, which was shared by many, was supported by several pieces of data. One example was a french-

speaking, upper-middle class woman who asked her husband, an accountant for the government, to "transmettre le message" that she would like to be appointed as the socio-economic representative in such-and-such a hospital. The appointment was made as requested.

The government waited until all other board positions had been filled before making its choice of socio-economic candidates. This allowed the government to make appointments "appropriate" to the kinds of board composition that had emerged. The two government officials I interviewed both maintained that the government appointed conservative individuals to boards that appeared too radical or troublesome, and, where a new board was safely in the hands of traditional authorities, it felt it could "afford" to appoint a union-affiliated candidate.

Union organization. Most French-speaking and some English-speaking non-professional hospital workers were members of the Confédération des Syndicaux Nationaux (CSN). This large Quebec labour union had highly organized leadership headquarters that included such specialized units as research, social planning, political strategy and membership development. Although a rival union refused to get involved in the reorganization of hospital boards maintaining that the government was merely trying to co-opt workers, the CSN decided to attempt to get elected as many of its members as possible. Making use of existing organizational structures, the CSN tried to organize hospital employees and to enter candidates and solicit support for them in the

patient elections. A series of "cahiers" and other bulletins were published to inform members of the impending reorganization and to instruct them on the organizational structure of hospitals and boards, the details of the legislation, the mechanics of assembly and so on. The union was, however, hampered in its efforts by many of the problems common to all such attempts at community or labour organization, but possibly also in this case, by their members' inability to perceive a role for themselves in hospital administration. Union organizers appeared to have had trouble convincing members that they were *capable* of being a member of a board of directors. From interview data and from the circulars it appeared that union members feared to expose their inexperience in what to them were unfamiliar and intimidating social milieux, and were more accustomed to participating in political activity as part of a group than as isolated individuals. In many hospitals, the campaigns never really got going, or succeeded only in attracting several candidates who split the vote and failed to get elected. Where "pré-élections" were held and single union candidates were entered, the union was more successful in getting representation on the boards.

In sum, then, the assembly of the new boards can be seen as a process of managing change. The administrators tried to influence the composition of the new boards by a variety of strategies that relied on their privileged access to information

and on the social organization and cohesion of the elite community. The government tried to control the political character of the new boards through judicious use of the socio-economic category. And the union tried to mobilize its membership to get "le monde ordinaire" elected wherever it could. Key variables in the process were organization and information. Those groups which had a relatively cohesive constituency that could be mobilized (the elites, the CSN) or had superior access to information (administrators, the government) competed for control of positions that had no clear-cut or politically aware contenders (users and socio-economics). The remaining positions were filled under the "supervision" of administrators and their senior advisors.

The New Membership

Analysis of the composition of the new boards that emerged from the first set of elections in 1973 is presented in Table VI. These data suggest that the new boards differed from those they replaced. The most notable change occurred in the percentage of board members from business and finance. In 1972 more than half the board fell in this category; in 1974 only 17 per cent. This difference was distributed over several categories, leading to a rise in the percentage of board members who were middle managers or semi-professionals, physicians, other health professionals, and blue-collar workers.

There is reason to believe, however, that Table VI may not

TABLE VI

Anglophone Hospital Boards Before and After Reorganization: Percentage Distribution of Members by Occupation Classification and Percentage Change

	1972	1974	Percentage Change
Business and Finance	55.7	16.7	-38
Non-Health Professions (lawyers, engineers, accountants)	17.6	18.8	+1
Physicians	12.2	21.0	+9
Middle Management, Semi-professions (teachers, social workers)	4.1	11.5	+8
Health Professions (excluding doctors)	.7	10.1	+9
Clergy	0.0	0.0	-
Housewife/Volunteer	6.8	7.2	
Blue Collar	0.0	6.5	+7
Other	2.9	8.2	+5
Total	100	100	
N	148	138	
Number of institutions	9	11	

Source: Le Conseil Régional de la Santé et des Services Sociaux de Montréal Métropolitain (CRSSS).

be an entirely accurate reflection of the changes that followed reorganization. First of all, the data assembled by the Regional Council were not well collected. Hospital administrators were required to submit a resumé of their new boards but were given no guidelines as to how to record the information. Consequently, no consistent categories were used to report the occupations of the new board members. When I compared the Regional Council documents with information I collected myself on three hospitals, there were considerable discrepancies. It appeared that administrators did not have the time for or the interest in tracking down the exact occupation of their board members. Moreover, they each used their own system for categorizing occupations. Thus, for example, administrators often tended to list a person who was, say, a vice-president of a company, as an "administrator," which put such a person in the "middle management" rather than the "business and finance" category where he would have been placed in the pre-Bill 65 analysis.

Secondly, Table VI is somewhat misleading in the sense that an occupational analysis does not tell the whole story about the individuals concerned. For example, the potential implications of a non-professional employee on the board were very different where he was a union-supported candidate from where he was a "loyal" hospital employee hand-picked by the administration. Consider, for example, Table VII which takes a detailed look at one particular anglophone hospital. First

of all, it can be seen that there were only 3 "new" faces on the new board of this particular hospital. All three of these individuals were selected by the administrator and his former board executive. Then, the problem of comparing before and after occupational statistics is evident in the difference between my categorization and that reported by the Regional Council. One problem that arises is the listing of board members as "retired", which put them into the "other" slot in Table VI. This and other such inconsistencies would partially explain the large drop in the "business and finance" figures in 1974.

The hospital analyzed in Table VII, however, is an extreme case insofar as other hospitals did not exert the same degree of control over the selection of new board members. Nonetheless, findings elsewhere support my suggestion that in general Table VI does not accurately reflect the changes that occurred after reorganization. Couture and Gravel (1977), for example, studied the new boards in six francophone health care institutions in the Lévis-Québec region. The authors report that half of the "user" and "socio-economic" representatives had "affinité de classe" with "la partie patronale." This "affinité" was defined as having managerial status in one's outside occupation. The study concludes that reorganization, particularly the nomination of user and socio-economic representatives, contributed "très peu . . . à 'démocratiser' les conseils d'administrations des etablissements de santé et de services sociaux du comté" (Couture and Gravel, 1977:211).

TABLE VII

Composition of One Anglophone Hospital Board in 1974: Representation, Occupation, CRSSS Listing[a], and Previous Board Affiliation of Members

Board Member	Representation	Occupation	CRSSS Occupation	Member of Old Board
A	Hospital Corporation	business executive	retired	Yes
B	Hospital Corporation	business executive	administrator	Yes
C	Hospital Corporation	business executive	businessman	Yes
D	Hospital Corporation	business executive	contractor	Yes
E	Patients	business executive	retired	Yes
F	Patients	housewife	volunteer	Yes
G	Socio-Economic Groups	accountant	accountant	Yes
H	Socio-Economic Groups	business executive	businessman	Yes
I	Hospital's Doctors	doctor	doctor	Yes
J	Other Professionals in Hospital	nurse	nurse	No
K	Non-professionals in Hospital	orderly	orderly	No
L	University	lawyer	lawyer	Yes
M	Interns and Residents	doctor	doctor	No

[a]Occupation listed in data of Conseil Régional de la Santé et des Services Sociaux as in Table VI.

In sum, I am suggesting that the first set of "new" boards did not look as dramatically different from their predecessors as Table VI might indicate. Incumbent hospital authorities exerted considerable control over the selection process and the changes that did occur--such as an increase in the number of doctors and the presence of at least two hospital employees of an occupational rank beneath that of physicians--were minimized by the fact that they were "hand-chosen" by the administration.

Despite their "approval" by the administration, however, several new members on each board had social backgrounds, experiences, and interests that were different from those of the business and professional executives they replaced. Often, they had not previously sat on a board of directors and, because both the form and the substance of board work were unfamiliar to them, they could not be expected to behave in the same ways as did their predecessors. The next phase in the management of change, then, was the control of how the new board members behaved once they took office.

Managing the New Membership

Three groups of factors have had the effect of neutralizing or minimizing the impact of the "new" members within hospital boards. First, certain structural or organizational factors limited the participation of many new board members. Second, hospital administrators and others attempted to impose

"guidelines" on board member behaviour, to socialize them into approved roles. Third, administrators tried to manage how board business was carried out through the use of certain procedural techniques.

Structural Limitations on Participation

In anglophone hospitals most new board members appeared to participate very little in board deliberations and to be very marginally involved in decision-making. Many of the factors responsible for this limited participation were "structural" in the sense that they were *inherent in the social situation.* The nature of boards of directors and hospitals, the social status of trustees and their relationship to the institutions they governed generally militated against the free and active involvement of board members.

The first of these "structural" inhibitors to participation was deference to boards of directors in general. Boards have a certain mystique for many people, as was echoed by almost all the "new" board members I interviewed.

> At first I could hardly believe it. Me on a board? A board has a lot of power and responsibility. I felt strange sitting around that table. . . . I was a little nervous. I didn't feel I had much to say. (NBM R)

Deference to the board as an institution was expressed even by some out-spoken union-affiliated board members, despite a concerted effort by union organizers to demystify board work.

This deference was generated at least in part, by the bureaucratic supremacy of boards, their presumed organizational importance, and a lack of public awareness of what they actually did. Deference was also related to the social stature of the people believed to sit on boards of directors.

> Je ne suis qu'une mère de famille, et eux, ce sont les hommes d'affaires très connus, c'est le monde extraordinaire. . . . (NBM I)

The social distance between "new" and "old" board members appeared to inhibit the active participation of the former.

> Poor old Mr X (orderly), he didn't open his mouth the whole year. I think he felt a little out of his depth, having lunch with company presidents at the Club, where we have our meetings. (Admin J)

Members who disapproved of rather than admired the "old" board still felt "intimidated" by the former board members and by the board setting in general, as is reflected in the frequent appeal for resistance to this posture in union circulars. For example:

> Prenez ça calmement. . . . *Ne vous en laissez pas imposer par de pretendus gros bonnets.* Souvent il n'y a que du vent en-dehors d'un gros bonnet. . . . (Federation des Affaires Sociales, 1973:11)

A second structural inhibitor on participation was the "insider" status of many new board members. Nurses, auxillary personnel and other hospital personnel who now sat on the board experienced certain role conflicts in making board-level

decisions on matters in which they had a direct vested interest. Moreover, they found it difficult to be hierarchically superior to the administrator in the boardroom while being subordinate to him in the context of their outside work. Hospital employees on the board often reported that they hesitated to question the administrator for fear of jeopardizing work relationships, influencing promotion possibilities and the like.

A third factor limiting the participation of "new" members was their own perceived lack of skill and experience.

> Pour eux je ne suis qu'une petite employée, plus ou moins intelligente, mais inconséquente. Les autres ont beaucoup plus d'expérience, mais moi, qu'est-ce que je sais de toutes ces choses? Je me sens vraiment impuissante. (NBM Q)

Perceived personal inadequacy was a deterrent to participation. Many issues with which the boards dealt were very technical and complex, and many of the new members had little previous managerial experience. This problem was exacerbated by the short terms of office stipulated in the legislation which prevented on-the-job acquisition of knowledge and experience. The new members often acknowledged that their value lay in representation of a point of view or in their particular organizational perspective, but they did not appear to view these contributions as "skills" in the conventional sense. That is, in contrast to the technical, visible relevance of such skills as training in accountancy or law, many new board members viewed their own potential contribution as vaguely useful but somewhat

marginal to most boardroom decision-making.

> I think I could tell the board a lot about how things work down here (emergency waiting room) that they don't know. But other things seem more important . . . . I guess they are, really. (NBM K)

Further evidence of such attitudes lay in the union's frequent attempt to bolster the self confidence of their members. For example,

> . . . la plupart des administrateurs n'en connaissent pas plus que vous. Dans bien des cas, ils en connaissent moins, ne possédant pas l'expérience que vous pouvez avoir des institutions. . . . (Fédération des Affaires Sociales, 1973:11)

A fourth factor working against the involvement of the newcomers was the absence of role models for lay participation in health care. I have already mentioned Stoller's finding of the significance of this point for the behaviour of lay members in certain American health planning boards (Stoller, 1972). Many of my respondents also had no clear conception of the kinds of contributions they could make in the area of medical care and were inclined to defer to the health professionals on their boards.

> It's all so technical, and besides, what does the ordinary person know about running a hospital or curing patients? Most decisions have to be made ultimately by the professionals. (NBM K)

The participation of elite board members, in contrast, was supported by relatively clear-cut role models established

through their long historical tradition of involvement in the health sector and through the greater apparent relevance and legitimacy of their expertise for the hospital.

The mystique of board work, the insider status of many new board members, disparity in the nature and level of skills and experience, and the absence of role models for lay participation in medical care were factors inherent in the social situation surrounding democratization that impeded the active involvement of many new board members.

Socialization

A second form of control over new board members was explicit socialization, or, "training" as it was called by those involved. Many participation projects conclude that "training" is critical to improving the quality and genuineness of public or worker involvement in organizational decision-making. It is maintained that consumers or employees have to be taught organizational details, administrative principles and other necessary components of decision-making. Training courses, instruction booklets, "How-to-be-a-good-board-member" guides, and a variety of other "educational" efforts are considered essential to any participation experiment. In other words, training is generally considered a good and democratic approach to promoting the involvement of newcomers in decision-making bodies. However, the fact that training is a way of controlling and managing the input of these individuals has been largely

overlooked.[1]

In Quebec, much effort was directed to training the new trustees, or, as one administrator put it, to "getting the board into shape." Within individual hospitals, new board members were taken on tours of the hospitals' facilities and given documents on hospital affairs. Sometimes a formal presentation of board rules and practices was held. Most "education", however, was carried out gradually and informally in the course of board or committee activities.

The attempt to manage the behaviour of the new trustees extended beyond individual hospital authorities. The Association des Hôpitaux de la Province de Québec (an organization including almost all the province's hospitals, considered "patronal" by hospital unions) prepared a "Cahier de Documentation" which was sold to hospitals to distribute to their board members. This document included a variety of information on the administrative structure of hospitals and the health system, and considerable discussion of the role of boards. This information, while trying hard to create the impression of objective documentation, was filled with normative analyses and interpretations of what the board "ought" to do or not do. The Association also organized several conferences to which board

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[1]One exception to this is a study by Metsch and Veney who noted in a study of consumer participation in health facilities, "Training is inversely related to consumer input. . . . Administrators may promote training to avoid intense consumer involvement if they understand this possibility." (1974:346)

members were invited to discuss their problems and share experiences. The literature distributed at such meetings also promoted a certain prototype of board member.

The government was also anxious to encourage its vision of the "ideal" board. Subsequent to the enactment of Bill 65, the Department of Social Affairs began to publish a quarterly review called 65 à l'Heure (recently re-named Carrefour des Affaires Sociales) which was distributed free to all social service institutions. Although it dealt with a variety of topics, the new boards of directors and the idea of participation was a recurring subject of analysis. Here again, the content of these articles was clearly a didactic and normative presentation of how the government would like boards to function.

These efforts of socializing new board members were supplemented by a fourth party, the union to which hospital employees belonged. In an attempt to prepare its membership for participation, the union organized regular congrès of union-affiliated board members to share experiences and plan strategy, and it published a series of "cahiers" which instructed their readers on how to be a "good" board member from the perspective of the labour movement.

But what was the content of this "education"? The main effort of administrators, the government and the Association was to provide members with the skills and information necessary to informed decision-making, but *at the same time* to direct

this participation into channels which were consistent with established practices of board work and which did not disturb the status quo. In contrast, the CSN's educational programs were aimed at promoting aggressive involvement and change in board work, although it did also try to furnish its membership with technical skills and knowledge.

Reflecting the administrators' concern for autonomy, one of the first instructions board members usually were given was to stay out of the day-to-day management of the hospital. One example comes from the hospital Association's manual, from a section called "Portrait Idéale d'un Membre de Conseil".

> Strictement parlant, un conseil ne gère pas. . . . De fait, en s'immisçant dans les affaires de gestion interne, le conseil peut briser les schèmes d'autorité et créer un chaos interne. (Association des Hôpitaux de la Province de Québec, 1973, pages not numbered)

Trustees were also cautioned that only certain matters were appropriate for board consideration. Personnel issues, for example, were to be handled at a lower level of management. In industrial settings a commonly reported "offence" of worker representatives on boards of directors has been their recurring tendency to bring personnel problems up to the board, bypassing normal administrative channels for such issues (Emery and Thorsrud, 1969). The refusal to deal with such matters at the board level was, in the case of my hospitals, a strategy for avoiding issues that administrators felt would be too difficult or

unpleasant to discuss within the new board format. Furthermore, much of the information and experience that such board members as the non-professional representatives brought to the board concerned those issues which were customarily handled at a lower hierarchical level. Refusal to discuss such issues at board meetings denied such members expression of their principal and sometimes only "expertise." Such insistence also reduced some of the potential interest such a board member may have had for board work because research in a variety of organizational settings has found that lower ranking employees are generally far more interested in local personnel matters and working conditions than in such broader organizational issues as policy and planning (Emery and Thorsrud, 1969).

> The union president asked me after the first meeting what had been discussed, but nobody ever asked again once they found out that the board didn't discuss wages and work conditions. That's all anyone is interested in, really. Unless something affects work conditions, they couldn't care less really. . . . (NBM R)

The suppression of personnel and "local" issues had the effect of controlling certain of the new board members.

A related form of "education" was rejection of the notion of representation. Board members were frequently reminded that they could not "wear two hats" and that they were on the board as individuals and not as the envoy of some special group. The fear of explicit representation has been mentioned in the literature (Douglass, 1973), but the issue has not been closely

examined. In my research the issue of representation was of consequence because it concerned power. Where individuals were known to speak for a larger body, particularly an organized constituency, their input was seen to carry greater weight than had they not been so affiliated. The playing-down of the spokesman role of board members was thus an attempt to minimize the power of individuals on the board, especially those who appeared most threatening to established patterns of hospital organization. Some administrations even tried to maintain that it was illegal for union members to sit on boards of directors and appealed to the government to require "desyndicalization" whereby unionized board members would have to renounce their union affiliation. This attempt to control the formal representativeness of board members was unsuccessful, but the effort supports my point.

At the same time as members were discouraged from assuming representative roles, their inputs were sometimes discounted because they did *not* do so.

> It wouldn't be so bad if you felt that these people represented others, but they only speak for themselves. (Admin S)

This contradiction supports my suggestion that the issue of representation was less an ideological principle than a practical political implement for controlling participation.

As new control needs arose, board members received appropriate corrective "education." The issue of confidentiality

is a good example. Shortly after the new boards were installed, the "problem" of confidentiality arose. To what extent should board deliberations be private or public? Certain matters were "leaked" to outside interested parties, and administrators and their elite executive advisors became alarmed and tried to prevent this "loss" of information. The hospital Association guide, for example, attempted to make discretion a moral obligation of the board member.

> . . . les membres du conseil doivent être capables de maintenir l'aspect confidentiel propre à ces situations et d'éviter la tendance à répandre une telle information hors de l'hôpital . . . il y a beaucoup d'informations . . . qui devraient rester à l'intérieur des murs de la salle du conseil. (Association des Hôpitaux de la Province de Québec, 1973, pages unnumbered)

Control was in the form of moral persuasion or "socialization," as is reflected in the "doivent être capables," and in the "ought to be" in the following quotation:

> At one meeting all new board members were told that meetings ought to be confidential. (BM H)

Where these socialization attempts failed to achieve the desired discretion, more forcible means were employed. In certain hospitals board members were requested to swear oaths of secrecy, a move that outraged many union members.

> . . . dans quelques hôpitaux il a fallu que les membres jurent silence à ce qui se passe aux réunions. Imaginez! Nous sommes les portes-parole! (NBM Q)

The issue of confidentiality will be discussed in more detail in the next chapter. Here, I use it to exemplify how control via "education" was applied to behavioural "problems" as they arose.

A more subtle form of socialization was also attempted. Many former elite board members and administrators felt that participation in board work would "educate" certain new members, that it would teach them how difficult and complex hospital administration really was.

> Now that she's on the board she can see a bit more the constraints and limits the board is under. . . . (Admin J)

This first-hand experience, they believed, would sensitize board members to organizational problems and promote their co-operation.

> You know the whole experience was a real eye-opener to X (unionized BM). He was astounded at the complexity. It's changed his whole attitude towards the board and he's become most cooperative. (BM O)

In the past, physicians had been put on the board with the expectation that they would learn to appreciate the non-clinical side of the hospital and more easily accept administrative constraints. In the new boards, neophytes were put on committees officially for "educational" purposes but also to pre-empt resistance or opposition. This strategy, of course, was a form of cooptation: it was hoped that board members would not only

become convinced of the necessity for such and such a decision, but also feel obliged to support it by virtue of being party to the decision-making process.

The possibility of cooptation was recognized and feared by the union, and their publications and conferences made frequent reference to the problem of assimilation, "le danger qu' ils (unionized BM) passent à l'autre côté, qu'ils deviennent les boss." The tendency for participation schemes to be controlled by cooptation has been frequently noted in the literature (e.g. Arnstein, 1969). The unions have gone to considerable effort to prevent it by organizing local groups to act as constituencies and to be a backbone to their members on the boards. The congrès for board members were also designed for "le support moral de nos gars." In hospitals with no organized union involvement, new board members were more vulnerable to this type of control.

In sum, then, I have shown that after attempting to control the selection of new members, administrators and their old board advisors then tried to control the behaviour of the newcomers. Under the guise of "education" and "training" much of this effort had the effect of socializing new members into approved roles and of reducing behaviour that was seen as potentially disruptive to existing administrative practices. This control was, of course, facilitated by such "structural" barriers to participation as status differences, board mystique and lack of technical knowledge.

Procedural Controls

A variety of other strategies were also used to manage the participation of certain board members in hospital decision-making.

Information control. Just as it was a tactic for managing the assembly of the new boards, so also was the control of information a strategy for managing the subsequent behaviour of members. Information was a source of power. The CSN recognized the politics of this fact and repeatly reminded its membership of their right to be kept informed.

> Il faut en faire la demande. C'est extrêmement important, parce que c'est une arme. (CSN bulletin)

Many hospital administrators expressed the desire to involve and inform new board members. At first meetings members were often presented with a variety of information on the history and organizational structure of their institutions. The provision of this kind of information served several purposes for administrators. Administrators felt that ignorance could be as much of a nuisance as too much knowledge.

> He wouldn't hear of it (a certain reorganization) at first. He thought that his people (union workers) would lose jobs. So we got him involved and when he found out more about it he changed his position. (BM O)

At the same time as giving background and other hospital documents to board members could sometimes forestall uninformed

resistance, it also functioned as symbolic reference to the good faith of the administration in giving participation "a fair chance." Sometimes, however, information was provided in such vast quantities that board members could not reasonably read it all or missed most of the detail. This technique of "flooding" preserved the appearance of cooperation while minimizing the risks of too wide a disemination of information.

Another strategy was to present the relevant documents only at the meeting. Insufficient time for study precluded commentary or objection because board members either did not know enough to make them or hesitated to expose their ignorance or miscomprehension.

> The minutes of the last meeting aren't given out till the next meeting, so you don't have any time to read them, and mistakes slip by. And with other things specific details are never given out till the meeting, and it's the specifics you need. In short notice you can't ask proper questions. (NBM T)

Another way information was controlled without outright concealment was through limited or strategic disclosure. One example was the issue of physicians' salaries.

> You can't have this kind of information floating about the hospital. So we couldn't really discuss it openly in front of the whole board. So what we decided to do was to bring the total of all the non-admissible salaries, *without a breakdown to the board. So this way they can't tell what the individual doctor earns.* (Admin A)

That is, documents were rearranged in a way that did not reveal

information that could be "misused."

A further type of information manoeuver was what might be called "consensus by default." At a board meeting the president would present a proposal or make a suggestion and then ask if anyone had anything to add or any alternatives. If the issue was being considered for the first time, few board members were likely to have well-formulated ideas of their own. The lack of alternative suggestions created an impression of agreement and the proposal was often accepted. The social interaction was framed in such a way that unless someone had a violent or fully articulated objection, he would tend to let the matter pass. An example was the formation of a complaints committee in one hospital to study a certain personnel problem.

> (How was the committee appointed?) The president stood up at the first meeting and suggested a list of people and everyone agreed, they didn't have anyone else to propose at the time. Now that we've thought about it a bit of course, there are several we would like to have named. (NBM R)

A final example of information control was the strategic use of government directives and administrative information. Administrators applied this tactic not only to the management of the new boards' composition (as we have seen) but also to the subsequent control of their memberships. "The government won't allow it" or "the budget is fixed" were frequently used by administrators to bolster their own positions. The CSN, however, tried to alert their members to this type of control.

> Il n'est pas vrai comme nous dit tous les jours le directeur général que le budget est tout à fait fixé. On nous dit toujours qu'on ne peut rien faire à cause du budget, mais cet homme (union organizer) nous a expliqué comment il faut le faire. Il nous a donné un numéro de téléphone pour nous permettre d'obtenir de l'information financière. (NBM Q)

Committees. A second example of procedural control was the strategic use of committees. In most hospitals decision-making went on primarily in committees which were set up, usually by the president, to study certain questions and report back to the board for final ratification. The law stipulated that an executive committee must be established, composed of the chairman of the board, a "user" representative, and representatives of the professionals, the physicians, and the university. The idea was that this group would be the active core of the board. Notably, the government did not include the non-professionals in this group. The heterogeneous composition of the executive committee was not welcomed by administrators and the "corporation" board members who had often comprised the executive of the former boards. They tried to retain their control by never forming such a committee, by formally naming it but never convening it, or by carefully controlling its membership.

> (What about the setting up of the administrative Committee?)
> Well, that was more or less pre-arranged. But that annoyed me. They have to have one patient so they put on the one who was from the old board without even asking the other patient. So the executive is all from the old guard. (NBM T)

The formation of most other committees was left up to the individual hospitals. Some committees were ongoing administrative units, such as finance and budget, while others were set up as needs arose, such as appointment committees, committees to study abortion, or the nursing shortage. Appointment to these committees was usually done by the administrator and the board president, enabling them again, to exert control over the outcome of these committees by selectively choosing their membership. Special care was taken in the appointment of the key committee of finance. Few newcomers got on this committee. In one instance a non-professional employee did get on the committee, and recounted what happened:

> They asked us what committee we would like to be on. I said that I wanted to be on the finance committee. They questioned this. It set them back a bit. They wanted to know why, so I said because I was interested in it and wanted to learn about it. Well, the next time I asked when the finance committee would convene and the president told me the finance committee had been dissolved!--(Why?) Because of me of course. Apparently they suddenly decided that since there has to be an audit committee because of the Act (legislation), they didn't need to have a finance committee. (NBM T)

Whether or not this was the "real" reason behind dissolution is unclear, but financial decision-making was taken up by the executive committee which was controlled by the administrator and his old board core.

An important strategy in the use of committees as a form of control was the appointment of elites who were not on the

board. Several hospitals adopted this practice, even in one case, to the extent of changing hospital by-laws to accomodate such a move.

> We ended up by having to change the by-laws to allow others to chair committees. Formerly, no one could chair a committee without being a member of the board. That's the only thing that has kept the place going since the new boards. (BM C)

This practice was often justified by the claim that new board members did not have the necessary expertise. Although there was undoubtedly some truth in this, it was also well appreciated that the inclusion of non-members on committees functioned to increase elite control over decision-making.

The committee system limited the participation of new board members in further ways. For example, because committees dealt with the details of issues, committee members naturally became better informed than the rest of the board which received only summary statements and recommendations and which was expected to rely on the committees' assessment.

> Les comités nous presentent une étude ou une recommandation et c'est à nous de la finaliser, de la sanctionner. *Nous ne pouvons pas faire autrement.* Si un groupe a étudié une question pendant plusieurs semaines et a fait beaucoup de recherche, le conseil ne peut que dire oui ou non car il n'a pas fait l'étude. (NBM Q)

By creating large differences in expertise between committee members and other board members, the board as a whole was more or less obliged to accept committee decisions. Since the

committees were largely controlled by elites or other "approved" trustees, new board members were further excluded from the inner sanctum of hospital decision-making.

Formality. A third form of procedural control was the use of formality. Most board meetings had always been relatively stylized formal occasions with the usual procedural rules and traditions. The former elite boards were accustomed to such ritual, but some of the newcomers had little or no experience in such customs and were bewildered by agendas, minutes, proposing and seconding, and the other bureaucratic trappings of group decision-making. In a study of indigenous community health advisory groups, Moore (1971) reported that classical theories of group process (cooperation, containment of aggression, respect for expertise) were developed in middle class milieux. On boards that were highly regulated (lessons on how to conduct meetings, referrals to committees, tight scheduling) local "lay" members were more passive and unquestioning than those on boards on which lay members were allowed to depart from the middle class prototype. The author suggests that forcing people into unfamiliar patterns of behaviour may diminish their capacity to meaningfully participate. In Quebec's hospital boards there was some evidence that procedural formality was a deterrent to participation. For example, the union circulars frequently exhorted its members not to feel intimidated by big words and "le grand apparat" (pomp and circumstance) of board work.

The adherence to formal procedures may have further hindered participation, as illustrated in this quotation:

> Basically we just stall things, we never got down to the nitty gritty. We leave it right until the end and then there isn't much time to go into it. For instance when we wanted to fire X I just waited till the end, *sticking closely to the agenda so the matter didn't come up* before, and then announced that this is what we had to do. (BM G)

That is, bureaucratic rules of conduct could be managed in ways that helped control the input of board members, particularly those who were seen as a "problem" to the administration.

Summary

In this chapter, then, I have looked at some of the ways in which change has been controlled in the reorganization of hospital boards. Administrators, in most cases in collaboration with their two or three core elite advisors, were able to manage the assembly process in such a way as to recruit mostly former elite trustees, "friends of the hospital" and other approved persons to the new boards. Nonetheless, on most boards there still remained some unknown and hence less predictable members. A variety of factors inhibited the participation of these new members and the suppression of what administrators saw as potentially disruptive behaviour was attempted by socialization and by procedural manipulation.

Despite the ability of administrators and former elite

board members to retain considerable control over hospital decision-making, my research indicated that reorganization has nonetheless had an impact on the nature of board work and on the structure of hospital decision-making. In the next chapter, then, I look at some of the social consequences of the "democratization" that did take place.

CHAPTER VII

SOME EFFECTS OF REORGANIZATION

This chapter analyzes some of the social consequences of reorganization. In the light of the description of the elite board system in Chapters V and VI, I ask: what effects did democratization have on the nature of board work and on the distribution of power in hospitals? First, the chapter considers some of the changes introduced by the loss of membership homogeneity. Second, it examines the influence of the new boards on administrators and their relationship with their boards, their employees and the medical staff.

The Consequences of Social Heterogeneity

The new hospital boards were no longer comprised exclusively of people from the community's upper classes. Even in those institutions where incumbent authorities exerted maximum control over the assembly process, the boards nonetheless included individuals from a broader range of social and occupational backgrounds. Members no longer knew or "knew of" each other to the same extent they had in the past. They were less likely to meet or speak to each other outside the boardroom because their social circles did not overlap or because they worked in unrelated occupational settings or on widely separate

hierarchical levels.

Stinchcombe's (1965) concept of the "liability of newness" is relevant to an understanding of the consequences of this heterogeneity. In a discussion of the social conditions that influence the founding and survival of organizations, Stinchcombe notes that relationships between an organization and its environment and between members within the organization are important factors in the ability of the organization to succeed. Of particular importance is the notion of trust. The "liability of newness" consists in part of the problems of establishing and maintaining trusting social relationships within and without a new organization. Dalton's (1959) analysis of the informal social organization of a business enterprise also documents the importance of trust in organizational life.

The New Boards and the Issue of Trust

The impact of democratization on Quebec's hospital boards can be seen from this perspective. I propose that an important "liability" of the new boards was the severance of trust relationships and the difficulty of establishing new ones.

The reduction of interpersonal bonds. The family, friendship, business, and class ties that linked trustees in the old board structure were substantially reduced after reorganization.

> You could rely on the old type of board member. If he said he was going to do something, he would. And

> you knew you could count on them to support you too on certain matters. You didn't have to check up all the time. But with these new people, it's just not the same. You don't know them at all. How do you know how they will react to something? And will they stick behind you? (BM E)

Relationships between strangers differed from those between friends, relatives, or even business associates. Individuals were less able to predict and rely upon each other's behaviour because it was sometimes based on mutually unfamiliar assumptions and values. Moreover, with the disruption of former processes of interpersonal influence (e.g. "working on" friends, business ties suppressing dissension), board members found that they had less control over each others' behaviour. That is, interpersonal trust was reduced less because the old board members perceived the newcomers to be actually unreliable as much as because they felt insecure in their ability to anticipate and influence their behaviour.

Status inconsistency. A second factor affecting the level of interpersonal trust within the new boards was the heterogeneity and inconsistency of the social statuses of the various members. Company presidents and hospital orderlies sat next to each other around the boardroom table and neither felt very comfortable about it. First, there was class distance between them. As one elite board member observed,

> We used to all talk the same language, we would speak to each other like at the club--not that it is like a club, but you know what I mean. They knew what each other were saying. You can't say the same things

> anymore. You have to be careful in case anyone interprets you as being condescending or hoity-toity. You have to be very down to earth, speak slowly. These people just don't understand much about these things. (BM S)

Class consciousness, in several instances, appeared to have maintained a social barrier between board members.

> I feel a bit funny there. They are such important people. (NBM R)

> He's a very nice man, really (non-professional employee) and I've even become quite budsy with him, in a distant sort of way. *You can't get too friendly* or it will look as though you are trying to coopt them. (BM O)

Hierarchical differences in board members' status influenced interpersonal relationships. As has been noted in the literature on organizations, communication between different hierarchical levels is problematic. For example, individuals feel more comfortable interacting with their status equals than with those subordinate in rank to them, and vice versa (Blau and Scott, 1962). Quebec's new hospital boards, however, bestowed formally equal status on all board members, making confrères in the board room people who were hierarchically widely separated in their external occupational roles. Some board members expressed ill-ease with this discrepancy in terms of skills and knowledge.

> A maintenance man working alongside the president of a multinational corporation . . . it seems a bit awkward doesn't it, their skills and experiences are just so different. . . . (BM D)

However, hierarchical distance between members was *in itself* disturbing to many. People seemed to share a certain definition of hierarchical propriety: it was inherently more proper for certain people and not others to sit on boards of directors. It appeared as if individuals had so internalized the prevailing hierarchical structure of organizations that they perceived unnaturalness or disharmony when this order was violated. Individuals did not dissociate board members from their outside statuses. An electrician on the board did not take on the elevated social status of board member, but remained an electrician. Board members were seen less as individuals with their own personal potential for contributing than as incumbents of certain social positions. Consider, for example, the following administrator's remark:

> We have *an electrician* on the board I really don't know how that will work, *the general manager* dealing with *an electrician* at the board level! (Admin S)

Representation. A third factor behind change in interpersonal trust was the issue of representation. Although the former elite boards maintained that they "represented" the community or the hospital "shareholders", the notion of representation became more explicit after reorganization. Because board members were now "elected", "designated" or "appointed" by specific constituencies, such expressions as the "patient rep" or "socio-economic rep" became common. Administrators and old board members often perceived new board members as oriented more towards

their constituencies than towards the board as an organizational entity.

> I tried to stress to her (new board member) that the board required a certain number of obligations to the board. But she doesn't understand what her responsibilities are really. *She has no loyalty to the board, only to the professionals.* (BM G)

Empirically, however, board members appeared to feel only a weak commitment to those who appointed them either because they had no definable constituency (e.g. the patient and socio-economic representatives), or because the constituency expressed little interest in their board representation.

> At a meeting of the PAC (in-hospital professional body) I gave a report and told them what had gone on at board meetings. . . . Only about 40 out of 200 came to the meeting. . . . The executive has never even asked me what has been going on. (NBM N)

Union affiliated board members were the most likely to perceive a representative role for themselves. Subsequent to Bill 65 union officials had been developing "CLAS" (conseils locaux d' action santé) and "CRAS" (conseils régionaux d'action santé). The former were local, hospital-based groups designed to "back up" union affiliated board members, while the latter were regional bodies intended to coordinate CLAS activities and develop plans and policies for action in the health sector. Although such groups were not organized everywhere, they nonetheless represented an effort towards increasing the accountability of elected board members.

There was, then, only limited evidence that board members actually perceived themselves or behaved as "representatives" of their constituents. Nonetheless, elite board members and administrators believed that new board members did not identify with the board in the same way as did their elite predecessors, and they attributed this to their role as representatives. A more likely explanation for this perceived lack of identification was that many "new" board members were not tied socially to the board in the same way as elites had been. Moreover, not knowing other board members, nor the customs and rituals of board work, new board members either failed to acquire a sense of group identity or did not express this attachment in ways understandable to the elites remaining on the board.

The representation function of board members was considered responsible by administrators and their former board advisors for the appearance of "conflict of interest."

> Many of these new people just push special interests, they're just out to toot their own horns. They're not neutral anymore. (BM F)

In the past, we recall, elite board members had been seen as "impartial" despite specialized skills, particular institutional affiliations, pet projects or ambitions for the hospital, and vested personal stakes in their directorships--the very characteristics identified as responsible for the undesirable partisanship of certain new board members. Thus, concern with conflict of interest reflected not that there were more "special

interests" than in the past, but that the "new" interests were less peripheral to hospital affairs than the "old" interests of elites, and that they were potentially mutually contradictory. However, whether or not new board members actually had or were only perceived to have divided loyalties and conflicting interests, the issue of representation contributed to the general decline in internal board trust and solidarity.

Confidentiality. The issue of confidentiality was one of the clearest manifestations of the change in trust relationships incurred by board reorganization. Before democratization no one had given much thought to what extent board activities were a private or public matter. Minutes of meetings were taken, of course, but because of the nature of board decision-making (committees, prior informal discussions) they included very few details. Official decisions or other relevant documents were circulated to heads of departments and to whichever administrators they concerned. No formal policy existed on the confidentiality of most information because none was necessary. Board members and administrators relied upon each other to be "discreet where the situation demanded it" as one trustee explained it. Former board members and administrators appeared to share common definitions of the situation and to follow similar codes of conduct.

Soon after the new boards took office the issue of confidentiality arose in several hospitals. Information was "getting out" that many felt should never have left the boardroom.

> There has been a change in outlook. How do I say it? I guess it's a question of ethical deportment or something. I have very high respect for the non-professional representative, and a nurse is representing the professionals. Still, the nurse is expected to report what went on. Now there are certain things that shouldn't be made public, do you know what I mean? (Admin A)

Confidentiality, of course, was related to the issue of representation. Because new board members represented specific groups, it was not unreasonable for them to report back in some way to their constituencies.

Confidentiality became a problem particularly in times of conflict or when hospitals experienced organizational difficulties. In some hospitals certain new board members demanded that everything should be made public, that minutes should be published, and even that board meetings should be videotaped. Such demands caused great alarm among administrators and other board members, even in hospitals experiencing no confidentiality problems at all.

Hospital administrators and "old" board members insisted on the need for confidentiality in a number of areas. Often cited as examples were salaries, particularly those of the medical staff. It was also felt that law suits against the hospital needed to be "kept quiet" to avoid bad publicity, and that real estate transactions should be kept confidential to avoid speculation. These were the official justifications offered for the "need" for confidentiality. It must be noted however, that if confidentiality was not an issue before Bill 65 it was not

entirely because elite board members were naturally discreet. For a large part, it was due to the simple fact that few people expressed any interest in what went on at board meetings, obviating the necessity for information to be kept "confidential". On the other hand, elite board members *did* discuss board affairs with non-board members. Usually, however, they talked with members of their own status group, people who had no cause, in their view, to misuse the information. Democratization, however, broadened potential public access to board activities. Hospital employees, members of other organizations, and union militants could get on boards and pass information on to their constituents or friends. What changed, then, was less the nature or amount of information that left the boardroom as much as the *audience* with which it could be shared.

Confidentiality thus became an issue in the new boards both because the boards no longer had normative control over internal information and because the information that did leave the boardroom was accessible to groups whose interests were no longer necessarily congruent with those of the hospital administrations.

One implication of the boards' loss of control over information was the potential increase in the visibility of board work. Little is known outside directorship circles about how boards of directors operate or how decision-making is conducted. The more open membership, shorter terms of office, and higher turnover rates of the new hospital boards exposed to a much

wider public than before such organizational "nitty-gritty" as personnel conflicts, detailed financial statements and the politics of administration.

The increased visibility of board work affected the elite trustees on the board. For example, in recalling the "showcase" and career mobility functions of board work in the former board system, one notes that mistakes and weakness could be displayed as well as skill and competence, and that conflict was assiduously avoided so as not to disrupt business or social alliances (e.g. Presthus, 1964). These "risks" associated with such philanthropic activities as board work were accentuated in the new hospital boards, particularly where "negative" information on the elite board members could be used as grist for political mills.

> These new boards are a risky thing, I mean the more people that are involved the more that gets around, and if someone goofs on the board then everyone can see. . . . And you never know how that kind of information can be used or blown way out of proportion. (BM Y)

> Nothing is done in confidence anymore. I mean 30 seconds after the meeting is over one of them (BM) is down there telling all their friends about how we don't know what we are doing. (BM G)

Board members also reported that they felt ill-at-ease discussing certain issues within the new board structure.

> How can we possibly discuss personnel problems here anymore, or having to fire someone, if what we discuss is all around the cafeteria tomorrow? It

> inhibits you, you just can't talk freely about things anymore. (BM E)

The literature on experiments in participatory management support the observation that public scrutiny can inhibit candid deliberation.

The perceived loss of confidentiality also appeared to erode feelings of group solidarity.

> Things aren't confidential anymore. There isn't the common sort of agreement that there was. *Nothing is sacred on the board anymore.* (BM G)

The use of the word "sacred" underlines the fact that confidentiality was a normative issue. Confidentiality and group integration were reciprocal social forces: the observance of confidentiality norms promoted a sense of in-groupness, and this cohesion in turn tended to ensure that confidentiality was maintained.

Procedural norms. Interpersonal trust within boards was also affected by the fact that many new board members did not observe traditional board work norms and role expectations. That is they did not behave in ways administrators and old board members considered appropriate for "executives." Administrators and board members complained frequently of the "inefficiency" of the new boards, attributing their frustration to the inability of new board members to cope with board-level business.

> The meeting takes much longer now, we would never talk about taking out a bond, they wouldn't know what a bond was. We would never talk about financial matters, because they don't know what we're talking about. It is really unbelievable. (Admin B)

Former board members were accustomed to talking about financial and other administrative business without elaboration because most members understood at least the fundamentals of the discussion. These members reported that the flow of business in the new boards had been slowed by the necessity for explanation and clarification.

> A friend of mine who is president of a large French hospital said to me 'Did you hear? At our first meeting it took 45 minutes to get the minutes approved?' (BM P)

Further contributing to the perceived "inefficiency" of the new boards was many new board members unfamiliarity with the plethora of small procedural understandings that were taken for granted in the old board and had facilitated board business.

> If I were to call up the patient rep and I wanted to have something done *I would have to start from scratch and explain everything,* to write up a memo and so on. Before the president would have called me up and said do such-and-such and I would and I would write him a memo on what I had done. That's the way these things are done. (BM S)

Many administrators and old board members found it a nuisance to explain what they considered to be "trivia", although at

times their annoyance appeared to stem more from having to account for practices for which there was little rationale beyond administrative ritual.

> . . . he (NBM) asked inane questions, questions you can't even begin to answer because they just aren't appropriate! Not everything has a reason, *it's just done that way*. The whole meeting is taken up explaining. (BM L)

New board members were seen as committing further "improprieties" because they did not share the former administrations' conception of the function of a board of directors.

> Instead of things moving through board meetings efficiently and fast, it becomes a debating society. They (NBM) don't understand that the board meeting is not for debating issues. That's all done in committees. They argue these things out in the wrong places. (BM W)

In particular, almost all old board members and administrators reported that newcomers did not appreciate what constituted a "matter for the board" and brought up what they perceived to be inappropriate issues.

> They (NBM) bring up ridiculous subjects (story about entertainment wagon wheeled around to patients). We must have spent four hours talking about the hospitality wagon. Whether there should be this or that on it . . . beyond belief! At the meeting of the board of directors! (BM S)

As much at issue as "inefficiency" was a sense of moral indignation that the institutional stature of the board as the highest organizational authority was somehow tarnished by

having to deal with matters usually handled at lower hierarchical levels. Personnel issues were considered particularly inappropriate not only for bureaucratic-administrative reasons ("The board is for policy and not for daily management") but also because they violated traditional board norms of detached objectivity and disrupted the "sentimental order" (Glaser and Strauss, 1965).

> And the patients' complaint committee! Ye gods! Everyone got so worked up. It was so emotional (story about food distribution problem) . . . and they fussed whether the elevator man disliked them . . . . The board used to be only concerned with matters of finance, budget, liability. Nothing emotional, sentimental. Nothing much about human problems. I've never seen someone cry at a board meeting before. (BM S)

As these data suggest, many board members, particularly those who had been on the old boards, felt ill-at-ease when the atmosphere at meetings grew "emotional". They felt similarly uncomfortable when there was open antagonism between members. In the past, elite boards generally functioned through consensus and cooperation. Internal disagreements were infrequent for two reasons: first, due to the board's social homogeneity, they did not often occur; and, second, due to group pressures, those that did occur were suppressed. This harmony was disrupted in some of the new boards.

> People have an aggressive attitude, as opposed to before where the board took an attitude 'let's get it done and work out a solution'. People are questioning the medical competence of the staff, things

> like this, and you can just see the hackles going up on the back of people's necks. (BM W)

To summarize this section, then, I have argued that an important consequence of democratization has been the loss of membership homogeneity and that this, in turn, has affected interpersonal relationships between board members. Board members no longer operated within the same frames of reference, with the same goals or with similar definitions of the situation because of a reduction in family, business and class ties between members, and because of such interactional problems as status inconsistency, conflicting role expectations, and the violation of traditional procedural norms governing board work. The loss of shared meanings and behavioural expectations had the important consequence of diminishing interpersonal trust and reducing the board's capacity for informal internal control.

The Effects of Democratization on the Power of Administrators

Changes in the internal social organization of boards have resulted in change in the function of boards vis-à-vis the rest of the hospital. In particular, the new composition has affected the kind and amount of control available to the three groups in the "administrative triangle". Because, as we have seen earlier, administrators were pivotal to the distribution of

hospital power, the analysis focuses mainly on change in their positions of organizational control. I look at the impact of democratization on the relationships between administrators and their boards, and between administrators and their medical staffs.

Administrators and the New Boards

Many of the factors that influenced the internal interpersonal structure of the new boards had direct consequences for administrators.

First, administrators could no longer relate to their boards as cohesive organizational units. In the past, we recall, administrators communicated with their boards primarily through the presidents or through a few key executives and assumed that they spoke for the rest of the board and could ensure its support of decisions that were made. With the new socially heterogeneous boards administrators had to carry on separate negotiations with a number of different sub-groups or individuals and could no longer always rely on the board to be self-regulating. Moreover, because of the variety of interests and representations on the board, administrators found it necessary to vary their self-presentations (Goffman, 1959) according to with whom they were interacting. Their approaches to a non-professional representative, usually their own organizational subordinate, could not be the same as their approach to an unknown layman or to an elite delegate of the Corporation.

In other words, instead of relating to the board as a whole and relying on its internal self-control, administrators had to orchestrate a variety of relationships with different sections of the board and negotiate consensus themselves.

A second consequence of reorganization for administrators in some hospitals was a loss of perceived personal administrative autonomy. Many administrators reported that new board members did not share the former board's respect for administrative independence.

> These guys (NBM) just don't seem to understand what the role of the board is. The point is not to get involved in day-to-day operations. That's my job. (Admin F)

Most elite boards had allowed their administrators considerable independence not only because they perceived it to be a managerial prerogative but also because they often did not have much time to devote to hospital work. Some of the new board members were equally busy and appeared equally willing to delegate responsibility (e.g. the University delegate) but certain others did not have such demanding jobs or outside pressures and became more involved than administrators wanted.

> We hold our meetings during work hours now, and X (NBM) figures that this is great fun sitting around a board table rather than pushing beds around, he's getting paid anyway. He doesn't care how long it takes. And he asks questions about all sorts of nit-picky things, things the old board would never have been bothered with. (Dr E)

Administrators and Hospital Employees

The administrators' control over hospital employees was also influenced by democratization of the board of directors. Formerly, as I have described, administrators were able to control the vertical flow of information up to and down from the board. After democratization, however, they were confronted with a board on which various hospital groups had formal representation. No longer were they the only source of information to "outside" board members, and their account of what was going on in the hospital had to be given to the board in the presence of hospital employees who sometimes had different views of the situation or even knew more about it than they did.

> He (admin) has to watch himself more now. With us representatives of the staff on the board he can't just do and say what he likes. The board used to be very isolated and only got what the executive director gave them. (NBM T)

This loss of control for administrators was magnified in hospitals where confidentiality was an issue. Not only did some administrators have less control over what entered the boardroom but also less control over what left it.

> Comment dois-je discuter ces choses là avec mes employés? Ils peuvent connaître ma politique. Je dois présenter ma plan devant mes employés! Et demain c'est répandue partout. On peut plus rien dire en surêté. (Admin G)

This change in the administrators' ability to control

information sometimes meant that boards were exposed to unfavourable details of their administrators' performance which undermined the trust relationship between them which, as mentioned earlier, was important to the administrators' autonomy. Moreover, the administrators' authority among hospital employees could be adversely affected by public knowledge of their performance at board meetings.

> I never realized before now much X (Admin) kowtows to the board. He is completely different from how he is with the rest of the hospital. (NBM T)

For administrators, in other words, loss of control over information could potentially entail a loss of power vis à vis both their boards and their employees.

The presence of "insiders" on the board created another difficulty for administrators: role strain. Administrators found themselves answerable to individuals who were their subordinates outside the boardroom. This contradiction made administrators fear that their actions towards these individuals as employees might prejudice their behaviour as board members.

> Je suis leur patron et ils sont les miens, si tu peux imaginer une situation plus illogique. L'atmosphère que ça donne; je ne suis plus à l'aise quand je leur donne les ordres, sachant qu'ils peuvent me flanquer à la porte à la prochaine assemblée du conseil! (Admin G)

Administrators felt insecure with "insiders" on their boards, invariably declaring something similar to:

> Supposing the director of nursing and I don't get along and I think that she should be removed, and I want to bring it up before the board, but she is on the board! (Admin C)

Although a firing-a-board-member situation never actually arose in the hospitals I studied, sensitive personnel issues and planning for an impending strike were two issues that administrators felt particularly uneasy about discussing with the new boards.

So far I have mainly discussed the implications of board reorganization that have entailed a *loss* of control for administrators. Certain features of the new boards, however, also functioned to *increase* the power of administrators. First, although the unity of the former boards had advantages for administrators, the more fragmented nature of the new boards meant that administrators could play members off against each other.

> I convinced X ("non-professional" NBM) to agree to the plan, and I knew that if he supported it, Y ("professional" BM) would have to go along too because it would look as if it were just the nurses who were objecting out of their own personal interests. (Admin B)

Administrators also found of course, that they had influence over certain new board members by virtue of their lower social status and their limited technical and managerial knowledge--factors that we have already seen exploited by administrators in their efforts to "manage" the new boards.

Administrators and Physicians

Democratization influenced another important contingency of the administrators' organizational power, the hospital's medical staff. As shown in Table VI on page 167, the average number of physicians on anglophone hospital boards increased almost 10% after democratization. At the level of individual institutions, three or four physicians were on the board instead of the one or at most two present before. In the past, we recall, physicians' input to top-level decision-making was traditionally made not through formal board representation but through such informal channels as outside social relationships with board members or contact with board members on committees. Consequently, physicians did not appear to value their increased representation. However, where these usual informal avenues of control were restricted by reorganization and particularly, where a situation of organizational stress made physicians really anxious to intervene in decision-making, use was indeed made of their formal representation, as illustrated here by a doctor who was embroiled in a dispute between the medical staff and the administration and who had suddenly become aware of the political potential of physician representation on the board.

> Now it is possible to get to the board through myself and X and Y (doctors on the board). If you can get a couple of nurses on your side and the resident, you practically have a majority! (Dr F)

In this case the physician became aware not only of the power

of direct representation but also of the possibilities for coalition and for the use of the board as an instrument of organizational power.

Doctors did not often make use of their formal representation in this way, but when they did, the organizational power of the administrator was often reduced. The mere structural possibility for such involvement of the physicians was a source of anxiety to administrators and was a factor behind their tendency to see reorganization as a threat to their personal administrative control.

Reorganization had a further consequence for administrator-medical staff relationships. Chapter V has shown how administrators used their elite boards as support vis-à-vis the physicians. Many administrators, however, felt that reorganization had undermined this political function of boards of directors.

> I don't have that same sense of security anymore; I can never be sure of the board anymore, never be certain that it will *stand behind me*. . . . (Admin C)

Specific examples of the consequences of this loss of support will be presented in the next chapter. Here, I wish to account for why the political role of boards was influenced by democratization by arguing that the new boards were not perceived of as legitimate by physicians. That is, they did not have the *authority* over the medical staff that the elite boards often had. To document this argument I show how the bases of the

elite boards' authority was changed by democratization of the membership.

Instrumental value. One factor that underlay the power of the "old" boards over physicians was their instrumental value to physicians in terms of financial support and external influence. Some doctors, however, perceived this "value" to have been diminished by reorganization.

> Up until Bill 65 I might have approached X (admin) with some plan, something we needed money for because we weren't able to get it from other funding agencies, lets say for three research fellows in the lab. X would go to the chairman and say, 'Can you help out these poor surgeons with $30,000 for salaries?' and he would say, 'Sure, OK, go ahead.' That doesn't happen anymore. He can't single-handedly just say that anymore. The whole board would have to consider it and it probably wouldn't get passed. You see, it used to be that a small group really ran the place, it was the same everywhere. The rest were just there as status symbols. The small group were interested and usually wealthy and these things were handled informally. (Dr D)

This physician was observing that the loss of homogeneity in the board's composition and change in the president's ability to speak for or influence his fellow members, had altered the informal social processes that had formerly characterized his access to funding or other support from the board. Insofar as the board's instrumental value contributed to their *authority* vis-à-vis the medical staff, and the new boards were attributed less of this instrumental value, reorganization has influenced the boards' political potential in administrator-medical staff relationships.

Expertise. A second basis of authority that was changed by reorganization was the perceived expertise of board members. As in other participation schemes, the philosophy behind Bill 65 was that certain representatives, particularly those of such constituencies as "patients" and the hospital's non-professional employees, were to contribute their perspectives and general experience rather than any specific administrative skills. They were meant to reflect the needs of the community or to bring first-hand experience in patient care to the board level.[1] Certain physicians, however, rejected the value of this kind of contribution.

> . . . it is all very nice and well to have these people on the board, they might be able to tell us something here and there or describe a situation for others . . . but you are not going to run a hospital on that! (Dr G)

That is, physicians questioned the *legitimacy* of the knowledge and experience of certain new board members. Physicians were professionals whose main claim to occupational autonomy rested on the technical and esoteric nature of their expertise (Freidson, 1972). They appeared to feel uncomfortable about being ultimately dependent upon and answerable to a board whose expertise was in their view, "unprofessional", that is, general, based on experience, and uninstitutionalized.

Further important factors in the authority of elite

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[1] Evident in the Castonguay-Nepheu Commission (1970), in parliamentary hearings on Bill 65, and in issues of 65 à 1' Heure.

expertise were its obvious relevance to hospital administration, and its unfamiliarity to most physicians. By contrast, *in the eyes of physicians,* the diffuse and general "expertise" of some new board members was only obscurely related to organizational problems, and was sufficiently "commonsensical" that it could be provided by anyone, including themselves.

> You don't need a patient representative on there to tell us that the clinics are overcrowded and the food bad. This information can come up through the administrator, or anyone else. (Dr C)

Furthermore, where new members were "insiders", physicians often did not consider their "expertise" as distinct or even complementary to their own skills.

> I don't really see that an orderly can tell the board very much that physicians can't also. (Dr G)

That is, physicians tended not to recognize as "legitimate" the expertise of new board members who were professionally subordinate to them and whose work experience overlapped so extensively with their own.

The expertise of certain new board members was also suspect to many doctors because of its potential for infringing on medical territory. Unlike elite expertise (legal, business and financial), knowledge of "community needs", "group experience", and other loosely defined competencies were seen by physicians as a potential threat to established professional jurisdictions.

> There is far more curiosity about details of all kinds of things from the newcomers. They are just trying to find out, I guess. But it makes things much slower. And physicians resent too many questions about patient care. That's not the role of the board. The old trustees stuck to their specific areas of expertise. (Dr F)

The definition of what constitutes the professional prerogative of physicians has been a source of conflict in other lay participation projects, witness the resignation of the medical staff of the Regina Community Health Clinic in response to the "meddling" of consumer board members in what the professionals considered to be clinical matters (Woods, 1974). The fact that many "new" board members were "insiders" increased the physicians' tendency to see them as likely to violate their professional rights.

Empathy. A third component of the authority of the former boards vis à vis physicians was the latters' perception that trustees "understood" and "respected" the medical profession's point of view. Some physicians felt, however, that new board members did not share this professional deference.

> Now (after reorganization) people (board members) are even *questioning such things as the medical competence* of the staff. You can just see the hackles go up on the back of the doctors' necks. They aren't used to being approached like this. (BW W)

> They have no conception of the tertiary hospital. They bring up the kinds of issues that are more appropriate to a community hospital. I mean when you go to all sorts of trouble to assemble a team, lets say in heart transplant, and you get so-and-so from there and so-and-so from here and you gradually

> get all the experts together, and they find themselves supervised by consumers. What do they know about all this? They say there is a need for more gall bladder operations instead! But hell, any old hospital can do these, *they just don't understand* the concept of a tertiary hospital. *The old board appreciated this kind of thing.* (Dr K)

Impartiality. A fourth basis of the former boards' authority over physicians that was altered by reorganization was the perceived impartiality of members. Physicians often expressed the belief that new board members, particularly "insiders", were biased and had "conflicts of interest".

> You can't be as objective emotionally if you work in the place. The old board went at it cold, and they could sit as judges. (BM Y)

Doctors believed that individuals could not make decisions independently of their occupational interests and goals. Physicians were, in general, not aware of the vested interests of elite board members because they were connected with occupational worlds with which doctors were not familiar and/or because they were too subtle and latent (e.g. class and leadership norms). New board members who were hospital employees, in contrast, had "interests" that were easily seen by physicians.

> Hospital employees (as board members) have an axe to grind usually. There's no way they be impartial in board decisions concerning their work or friends. (Dr A)

It is important to note not only that "insider" board members

had interests that were more visible to physicians than those of their elite colleagues, but also that these interests had a greater potential for conflicting with those of the medical staff. Moreover, inside board members had more direct "stakes" (Fox, 1971) in the hospital than the average elite board member. It would seem that the "impartiality" attributed the former boards rested on the *inequality of stakes* between trustees, administrators and physicians. By rendering these stakes more equal, democratization contributed to the physicians' tendency to perceive the new membership as lacking impartiality.

Prestige. The issue of prestige was a final factor in the decline of the new boards' authority over physicians. As we have seen, the social status of elite board members had "matched" those of many senior physicians and contributed to the latter's willingness to submit to certain board control. Many new board members, however, were of a lower social class than physicians and, in the case of "insiders", were hierarchically and professionally subordinate to them in their outside work lives. In their role as board members, however, these individuals were administratively superior to the medical staff as a whole and "colleagues" of the physician board members. This incongruence appeared to reduce the prestige of the new boards in the eyes of physicians.

> If you know that the board is just your own dietician or resident that will be running around the ward, I don't know, somehow just being a director doesn't give someone prestige. (Dr F)

Status discrepancies appeared to have strained interaction at board meetings. Several physicians, for example, observed that they felt uncomfortable about discussing certain matters with those insider board members who were professionally subordinate to them. Part of their discomfort might be understood through Blau's conceptualization of inter- and intra-organizational consultation as a process of social exchange (Blau, 1955). When a physician approaches a board member to make a request or some representation he symbolically places himself in a subordinate position and incurs "unspecified future obligations" in return for the board member's attention or support. Possibly this gesture of deference and dependency was acceptable to physicians vis-à-vis the former elite board members but less palatable when it had to be directed towards individuals of lower social status.

In sum, defining "authority" as the perceived legitimacy of a claim to power, I have argued that physicians did not grant the new boards the same authority as they had the former boards. In the eyes of doctors the new boards were no longer of such "instrumental" value to them and many of their members were seen to lack a "valid" expertise, empathy for medical perspectives, regard for professional autonomy, impartiality, and status equality.

This decline in the legitimacy accorded boards by the medical staff had implications for the distribution of power between doctors, administrators and boards of directors. The new boards of directors had fewer controls over the medical

staff than elite boards appear to have had and consequently were of less political usefulness to administrators in *their* efforts to manage physicians. Evidence of this appears in the three case studies in the next chapter.

Summary

This chapter has looked at some of the consequences of democratization for the nature of board work and for the distribution of control within the hospital, particularly between administrators, doctors, and boards of directors. The social hetereogeneity of the new boards influenced internal patterns of social interaction, especially by changing the bases of trust between members. Administrators acquired some control by virtue of the lack of experience and lower social status of certain new members. In many cases, however, administrators lost more power than they gained because they were less able to control organizational information and because the political support function of their boards was reduced by a decline in their authority over physicians.

CHAPTER VIII

THREE CASE STUDIES

The last two chapters have described the process of board reorganization and the new boards' effects on relationships between board members, administrators and physicians. In order to make the analysis more particular and integrated, the present chapter describes how such changes clustered within three individual institutions. Because the literature and my own research support the notion that the functions of boards are highlighted in times of organizational stress, the case studies describe how the new boards managed a serious organizational issue. The first institution, the Western Hospital, was studied during an organizational crisis involving a messy personnel problem and public scandal. The Highview and the Rivertown Hospitals were examined in relation to their management of a severe budgetary cutback imposed by the provincial government. Two implications of reorganization illustrated by these case studies are then discussed.

Western Hospital

Western Hospital was a rehabilitation hospital whose staff was mostly comprised of such professionals as physiotherapists and social workers. Its pre-reorganization board consisted of

the usual array of businessmen, lawyers, accountants, financial patrons and local citizens. In general, however, board members were not part of the same social circles as the trustees of the large teaching hospitals in the city and they were somewhat less likely than the ideal-typical board to know each other socially or through business. The administrator held very tight reins over the board and the staff, and allowed no communication between them except through himself. He was unpopular among employees and there was an active group of professionals who were particularly hostile to him.

The assembly of the new board in 1973 was marked by much political manoeuvering because the administrator was very anxious to preserve his organizational control, while the staff saw reorganization as their chance to be heard and avenge themselves of their grievances towards the administrator. The nomination and election processes were actively contended but were marked by distrust and acrimony. The administrator managed to get "his" candidates into most board positions. The "professional" slot was filled by an active member of the anti-administrator clique. This new member provided the staff with their long-sought access to the board. He made board work difficult from the perspective of the administrator and the board president (from the former board) in many of the ways I have described--bringing up what they felt were inappropriate issues, saying things the administrator did not want the board to know, reporting back to fellow staff members,

asking questions about the hospital's financial statements, protesting his illegal exclusion from the executive committee, and the like. The administrator and former board members tried to control his behaviour through such techniques as referring decisions to selected committees and putting contentious issues late in the agenda.

A few months after the new board was instated a vituperative personnel conflict came to the surface in the hospital. The staff accused the administrator of financial mismanagement and the appropriation of public funds. There was noisy press coverage of the "scandal". The board was taken by surprise; it had been kept so isolated from everyday hospital affairs that most members were not even aware of any hostility between the staff and the administrator. Board members wanted to trust the administrator; not to do so would reflect badly on their past judgment. On the other hand, the publicity was very bad, the vehemence of the staff compelling, and the evidence rather disturbing. The board had a difficult time managing the crisis. Little useful discussion could take place at board meetings because of the presence of the administrator and of the board member representing the professional staff. Rumours and board documents circulated freely. Suspicion and resentment almost paralyzed the hospital. The board hedged and set up committees and awaited the results of official investigations. The regional government office became involved and pressed for some resolution. The president and a few others met without

the rest of the board, and at last requested the administrator to resign.

Problems at Western Hospital did not end with this resignation. The new administrator that was subsequently hired found himself confronted with a legacy of personnel conflicts and other difficulties. In the "second round" elections (i.e. when the one-year terms of office expired), the administrator was not as successful at managing the change in his own favour as had been his predecessor, in part because the various constituencies had more time to organize and because the hospital did not have a well-established body of patrons to assist him. Several persons got onto the board whom the administrator and the remaining former board members were not able to control. The administrator became increasingly aware of the importance to his authority of "having a united board behind me", the lack of which contributed to the difficulty he had in resolving the hospital's problems.

Events at Western Hospital since Bill 65 illustrated many of the issues I have raised. We note, for example, that the original administrator had considerable control over the organization by virtue both of his gatekeeper role between the board and the hospital and of his ability to maintain the board's trust. His managerial independence depended partly on the relative geographical inaccessibility of the hospital to board members and partly on the fact that trustees did not appear to have been very interested in or committed to the

hospital, a situation that was possibly related to the paucity of social links between board members and to the absence of an active body of "patrons". By virtue of his extensive power over the organization the administrator "managed" reorganization in his favour. Nonetheless, the presence of one new board member over whom the administrator had little control resulted in the two changes identified in Chapter VII: the deterioration of trust between members and a shift in the balance of power within the hospital. Confidentiality problems, conflict of interest accusations, and a sense of uncertainty and suspicion in interaction between board members were manifestations of change in interpersonal trust, while change in the distribution of power was signalled by the administrator's inability to prevent board members from receiving information that was detrimental to him and which eroded their confidence in him and the autonomy contingent upon it.

In Western Hospital, reorganization of the board appeared to have two consequences of note. First, the new membership influenced the nature of board decision-making. Although the former Western board was not as socially cohesive as some other elite boards had been, it had nonetheless been characterized by a core executive group that carried most of the responsibility and relied upon the rest of the membership to support its decisions. The new board's executive, however, could no longer be certain of the support of the rest of the board. The board could no longer act as an integrated unit. Decisions were not

easily reached and emerged only after extensive debate and negotiation involving everybody. The laboriousness of decision-making during the crisis appeared to heighten antagonism and frustration and intensify the hospital's problems. In response to this situation board decision-making increasingly went "underground".

> We had to meet without X (problem BM). It was impossible to do or say anything without risking it getting out. We just couldn't rely on him like that. So a few of us met and got to the bottom of things. We had to act quickly, which you can't do with a board like that. (BM G)

The board's president reported that frank discussion was "impossible" in the presence of certain board members because they had "conflicts of interest" and could not be trusted to maintain confidentiality. He also maintained that these individuals could not "understand the issues" and "misconstrued" what was discussed. Consequently, more and more business was conducted outside the boardroom, usually by telephone, between only a few board members. The "scandal", of course, greatly increased this behind-the-scenes decision-making.

At the same time as one observes the apparent inefficiency of the new board structure and the tendency for decision-making to be conducted in private between a few board members, it must also be noted that reorganization provided an unhappy professional staff with access to a board that had previously been totally inaccessible to them. If the staff had not acquired

access to the board through democratization, the activities of the administrator and the festering personnel conflicts would have undoubtedly taken much longer to be recognized and resolved.

A second implication of reorganization for the Western Hospital board was the disenchantment of several former board members who found board work had become increasingly distasteful to them and who either resigned or expressed the intention of doing so.

> Unless you have some kind of social conscience these days you're not going to get involved. It's not very satisfactory anymore. First of all everything is in the control of the government. What's left for the board to do? And then if all you get is abuse for your efforts, thanks very much but it's safer to run the Rotary or the Squash club . . . I almost resigned in the midst of all this (scandal). I'd like to get to June and then get the hell out. If you're paid, OK perhaps you can stand some of the frustration and aggravation, but on a voluntary basis, I can't see how you are going to get good people to sit on these boards anymore. (BM G)

Many of the factors that had invited and sustained the participation of members in the former board structure were altered by reorganization. For example, some board members perceived the prestige of the board to have been diminished by democratization. Although this point was rarely expressed explicitly --to say so would have been to acknowledge the prestige factor in board work as opposed to more ideologically acceptable public service ideals--there was some evidence to support the possibility, for example:

> You know, you felt sort of good about being on boards before. Proud of it I guess. Somehow that's changed . . . . (BM A)

After democratization and particularly during the scandal, several board members found their hospital work very stressful. Interpersonal animosity, the perceived necessity for meetings to be strategically conducted, insecurity over confidentiality, and the perceived loss of "cabinet solidarity" as one board member put it, altered the formerly orderly and tranquil character of board work. The "showcase" function of board work became for some a liability rather than an asset as mistakes and political stances became more visible than they might have been within the "old" board structure. For example, the scandal blatantly implied, rightly or wrongly, that the board had not been adequately supervising the hospital's administration. Wide press coverage and the continuous leakage of information from the boardroom made every move risky for board members. There was some evidence that the conflict might have damaged the career interests of certain board members. For example, although insufficient in itself to confirm such a thing actually occurred, one businessman unconnected to the hospital commented about an acquaintance of his who was on the Western board at the time of the scandal,

> It was a messy affair. And I'm afraid it didn't do X (BM) any good at all. He came off looking rather poorly. It will come back to haunt him I'm afraid.

Highview Hospital

The Highview was a large, urban general hospital affiliated with a university. It's board of directors closely approximated the model described in Chapter IV. One of the oldest and most respected hospitals in the city, it was founded by a group of prosperous citizens and subsequently administered and developed by the city's upper-class community. The membership of its board of directors had always been drawn from prominent local families and the "top drawer" of business and the professions. Recruitment was conducted on the basis of personal or business relationships. In its recent history efforts had been made to recruit persons known to be "workers" as opposed to "sitters", and the executive group most often included one or more individuals who were retired and who approached their hospital work as a second career. The board was thus made up of people who knew each other personally and who were highly committed to "their" institution. The board was backed by a corporation made up of about a thousand "governors", people who regularly contributed financially to the hospital. Most of the governors, of course, did little more than write a cheque; only a handful used to attend their annual meeting. The hospital had a healthy financial history. Deficits had been kept low and a substantial amount of money was available annually from the corporation's private endowments and donations.

The administrator of the Highview at the time of reorganization was widely respected both within and outside the hospital. The board trusted him and accorded him considerable administrative freedom. The board had a very active committee system, and since doctors were often included on these committees, communication between the board and the medical staff was considered to be good. Physicians reported that they felt the administrator represented them well to the board, although they had their own avenues to the board through personal social links with trustees. Several times a year the most senior medical staff and the board executive got together, "for an informal dinner some place, maybe the club or someone's house", and discussed hospital problems. Board members were routinely included in search committees, further increasing points of board-staff contact.

News of Bill 65 and board reorganization were received with apprehension. When it became apparent that the unions intended to contend actively for board seats, the board swung into action. The close links between the hospital and the community elite and the social cohesion between board members were decisive factors in the administrator's and the board's ability to retain maximum control over the new membership. For example, the women of the Auxilliary, a large and active unit in the hospital, were enjoined to make use of their organization in the campaign to "save the hospital". Volunteers telephoned their own members, friends and "governors" to request their

presence and support at the "patient" elections.

The first "new" board was comprised of nine former elite board members, the medical representative who was on the former board, the senior nurse who had often attended previous board meetings, a trusted hospital employee who had worked in the hospital for many years, and a medical student. This composition did not change very much in the elections the following year.

In the fall of 1975 many hospital authorities became aware of impending budgetary restrictions. As elsewhere in industrialized nations, the costs of Quebec's medical care system had been increasing at a staggering rate and the strain on government coffers had necessitated severe financial restrictions within the health sector. In February, 1976, hospital administrators received a "directive" indicating that the 3.2% budgetary increase promised for 1976 would be reduced to .7%, which effectively meant a budgetary cutback of 2.5%. In multimillion dollar budgets such a reduction had significant organizational import, particularly for those hospitals (of which there were many) with outstanding deficits from the previous year for which the government had recently announced they would no longer pay. To handle this cutback hospitals had to examine closely all their services, eliminate any waste, and consider closing underutilized services, cancelling certain projects, reducing personnel and so on. Such decisions, of course, affected everyone in the hospital.

The administrator and the board executive had been alerted to these financial restrictions several months before they were imposed. They had already set up a structure to deal with the problem when the actual directive from the government arrived. Senior medical administrators had been advised and an existing budget committee was assigned the job of managing the cutback. This committee included the board executives, the medical department heads, and other administrators. Chaired by an elite board member who was a top executive in a large corporation, the committee rapidly set in motion mechanisms for meeting the new budget. A thorough examination of all hospital operations and preliminary voluntary departmental "fat-trimming" set the stage for orderly and relatively peaceful decision-making.

Because I followed only the earliest stages in this process and because it occurred only incidentally to the main thrust of my research, I obviously cannot evalute the hospital's performance in any objective sense. Nonetheless, I did observe that *relative to other hospitals* I studied, the Highview's early attempts at solving its financial problems were smoother, less conflictful and marked more by cooperation than by resistance. Why was this so? One explanation appeared to lie in the leadership of the Highview's board of directors. Several factors influenced its performance. First was the social integration of the board's membership. The new board had retained most of its former internal cohesion by tight management of elections and appointments and by careful control of

the behaviour of "out-group" board members. Second was the concentration of decision-making outside the boardroom. Because of the presence of a few "out-group" board members, decisions were made by an informal executive group which was all-elite and in committees which were chaired or otherwise controlled by selected elite board members. In bringing these decisions back to the whole board for ratification, care was taken to screen out information that was deemed undesirable for certain board members to know and to ensure that the decisions were approved.

A third and most important factor in the board's performance during the budgetary crisis was its authority over the medical staff. As I have discussed earlier, physicians traditionally have not easily accepted administrative control, particularly in "clinical" areas. The financial reassessment involved in meeting budgetary restrictions, however, required the scrutiny and justification of expensive pieces of equipment, of the allocation of space and support staff, and the use of certain treatment procedures, drugs and other supplies. Budgetary cutback clearly involved decisions on sensitive clinical issues. The administrator of the Highview made maximum use of the authority of his elite directors in his attempts to enlist the cooperation of physicians in budget reform.

> The committee meets every week and X (elite BM) rules it with an iron hand. It lasts 1½ hours and he wants to know what and why each department spends. He wants an answer and no fooling either. We have had

> tremendous cooperation from the doctors. At the X hospital they told the doctors to cut back and they announced they would go out on strike! (BM M)

> X (elite BM) chairs the budget committee meetings. Everyone turns up and takes the whole thing very seriously. He speaks nicely but firmly. He applies the rules of his business to the hospital. (And people follow his direction with no fuss?) Well, there always is certain disagreement; we all want someone else to do the cutting back! . . . but he speaks with authority; he really knows his stuff. He backs everything up with facts and figures. . . . My predecessor would never have had to account like this. But talented board members head the committees . . . people respect their advice because these guys know what they're doing. (Dr D)

Data such as these support the argument that physicians submitted to administrative control in part because they perceived its source of legitimate. The quotations allude to some of the "bases" of authority identified in Chapter V, such as executive style, the nature of expertise, and status equality.

In sum, the Highview Hospital embarked on the process of budgetary reform in an organized and decisive fashion that appeared to generate very little internal conflict compared to other hospitals. One factor in this scenario was the board of directors. Because the former board's elite members had managed to exert maximum control over the selection and behaviour of the new membership, the new board had many of the characteristics of the all-elite structure. The new board's internal cohesion and authority over the medical staff were important factors in the Highview's approach to the financial crisis and to the low level of conflict associated with it.

Rivertown Hospital

Like the Highview, the Rivertown Hospital had been founded and developed by private philanthropy. Some very important differences existed, however, in the social organization of their boards of directors. The Rivertown board was set up by a wealthy industrialist who secured a charter for the hospital that stipulated that the board be composed of 15 persons, seven of whom were appointed by the corporation (i.e. self-recruiting) and eight of whom were ex-officio, the chairman of specified companies and banks, the president of the local Board of Trade, the city mayor, and the principal of the university. These ex-officio positions meant that less than half of the members could be selected on the basis of the recruitment criteria that were key to the nature and function of the ideal-typical elite board, such as free time, friendship and family ties, particular skills. This recruitment restriction undoubtedly contributed to the board's reputation for not being very committed to the hospital.

> Half of them never seemed to turn up at meetings and the others didn't know much about what went on in the hospital. . . . No one ever seemed to ask about the deficit that just continued to grow year after year. No one seemed to care very much. (BM U)

Involvement and interest in the hospital was less likely in a board comprised of "involuntary" volunteers who, by definition, could not be retired with free time and second career interests,

or be middle-level executives with career stakes in doing a good job.

The physicians generally found that they could get what they wanted from the board, "with a bit of squeeze", but many felt it had no power and resented its members' ignorance of the hospital.

> Of the old guard type who were around here I'd say 80 per cent didn't have a clue what was going on, and most of them participated even less than they knew. They were useless. (Dr. F)

There were few lines of communication between the board and physicians. Unlike at the Highview, informal "get-togethers" rarely occurred, trustees were never included in search committees, and, although there were several doctor-patient links, there did not appear to be as many personal social relationships between trustees and senior doctors. This lack of contact between board and medical staff and the latter's consequent perception that board members did not "understand" their problems counteracted the authority that adhered to their status and imputed expertise.

> That was the trouble with so many of the old guard. They were famous, and they were competent, but they just didn't have the time, they weren't available. (Dr. C)

In contrast to the board of the Highview, Rivertown's board had less legitimacy vis à vis the physicians and thence less direct or indirect (through the administrator) control over

them.

Administrator-staff relationships, also in contrast to those at the Highview, were very strained. The administrator limited his contact with doctors to an absolute minimum, feeling that they were "medical primadonnas" who "switch their allegiances" and who would "take over the whole hospital if they could". The physicians in turn felt very antagonistic towards the administration,

> The administration here is incompetent. And because they can't manage they hire more incompetents to cope. Red tape increases all the time and there is nothing to show for it. We propose things to X (admin) and they go up and we never hear a thing about it again. Everyone is very discontent about the administration. (Dr. A)

In the first "round" of reorganization the administration and the former board succeeded in getting elites into the four "patient" and "socio-economic" slots. This result, however, was achieved more by default than by organization: there was little involvement of the Womens' Auxilliary or the corporation in the campaigns and little organized opposition to the board's candidates. The following year, however, two prestigeous elite board members were defeated in the patient elections by a hospital technician who had organized professionals to come out and vote for him, and by an "unknown" layman whom the elite board component believed to have been "put up" by the CSN. The fact that the elite candidates did not even attend the election is in itself suggestive of the degree of

indifference that characterized the hospital's former board.

The impact of this new board was similar to what occurred in other hospitals. One of the new members was defined as a "problem",

> He shook the place up alright, but all at the wrong times. He got everyone's goad up. (Dr. C)

As elsewhere, elite board members were disturbed by status inequality among members and by the lack of "executive behaviour" in newcomers, and they felt the board was weakened by normative dissensus and by dilution of its expertise. The administrator felt his organizational control threatened by the new board. Hospital employees, particularly the physicians, now had direct access to the board.

> You couldn't get anywhere with the administration here. So we went over his head. We went directly to the board and told them our problems ourselves. (Dr. C)

The board's political function in the distribution of hospital power was diminished by its inability to operate as a cohesive unit and its reduced legitimacy in the eyes of physicians.

> Now if you have, as we do, a board chairman of this position (top executive) he just says, 'I'm sorry but we discuss it at the end of the meeting, if you'd like to take it up with me personally'. People of this sort can carry that off and keep people in line . . . . I mean can you imagine how the Chief of Medicine would react to a hospital secretary? How could she ever control a committee? (Admin R)

The administrator and his elite executive core attempted to channel the participation of the new board members by many of the procedural strategies described earlier. Non-member elites were put on committees to keep decision-making in the "right hands", and key or sensitive deliberations were conducted outside board meetings.

> Primary decisions are just not being made at the board. It is just rubberstamp. The board is circumvented. Anything could be discussed at the old board, but it just isn't possible to take many things to the whole board now. (Admin R)

> The meetings have been undermined by the new board members . . . so we get up a policy committee, the top four medical people and four key board members (elite) and we meet every month. We don't talk trivia. If you can't come too bad for you. It is never more than an hour and we leave with a decision made. (BM B)

A further implication of board reorganization at the Rivertown was the dissatisfaction of several elite board members.

> You just aren't going to get good people on boards anymore. Some of the best are just not coming to meetings anymore or come less and less. There is hostility instead of homogeneity. It's driving good people out. (Have you had trouble getting new board members?) Yes, They turn you down. They don't want to spend their time fighting. My friends in industry say the same when they have workers on the board. Everything has to go on in a back room, and they are losing their people too. (BM W)

Displeasure with the new boards, combined with resentment of increasing government intervention in hospital affairs, and bureaucratic red tape, were factors in the resignation of two

elite board members and in the admission by two defeated "patient" candidates, that they were "secretly quite relieved to be rid of the chore".

Board reorganization also influenced the Rivertown's handling of the financial cutbacks imposed on the hospital. When the government's budget directive arrived, the board and the administration were much slower to react than their counterparts at the Highview. A group of physicians requested a formal budget control committee in which professionals could be involved, but none materialized for many months.

> The doctors have been trying to get the kind of budget review mechanisms that the Highview has for ages now, but the finance department seems to feel it would be criticizing them, they feel defensive about it, they don't want to go over the budget. (Dr. C)

A number of other committees were set up but proved unproductive for a variety of reasons including failure to ever convene, and a chairman for whom the professionals had little respect. The board did not take initiative in managing financial reform. Decision-making did not appear to be organized or centralized in any consistent way and the hospital staff stewed in anxiety, frustration and distrust because they had little confidence in the way the crisis was being handled.

> The bureaucracy here is unbelievable. But we are told we have to save, we've got to cut back. How many bureaucrats do you think they will cut? None! No one seems to be doing anything except talking about it. X (administrator) just chops as he sees fit without a moment's consultation with the doctors

> who are the one's doing all the work around here. And the board just sits on its ass. (Dr. K)

Although the performance of the board in the early stages of budget crisis was influenced by its historical lack of involvement in the hospital, poor relationships with physicians, and recent administrator-professional staff conflict, the new social structure of the board was clearly a factor in its own right. Change in the social cohesion and interpersonal trust between board members and the diminished authority of certain members in the eyes of physicians, contributed to the difficulty the board had in developing an acceptable forum for decision-making. On the other hand, the new board composition eventually played a positive role in the hospital's efforts to solve its financial problems by promoting the departure of the board chairman and by enabling his replacement by an individual with more interest and legitimacy than his predecessor. When the chairman resigned--in part because of his frustrations with democratization--a group of militant doctors used their increased representation and influence over certain new board members to refuse the successor proposed by the "old guard" trustees and to nominate and elect their own candidate.

Discussion

The general *nature* of the consequence of board reorganization was similar in all three institutions, although their

extent varied widely depending on the social structure of the former board and on the hospital's particular organizational situation. Three themes can be distinguished.

Retrenchment of Decision-Making

One experience common to all three hospitals was an apparent increase in the concentration and covertness of decision-making. Although in the past most decision-making had rested in the hands of an executive clique and the administrator, this distribution of power was largely by default rather than design and the participation of other trustees was essentially at their own discretion. Decision-making had been an informal process that was closely linked to the social homogeneity of the former board's membership. New "out-group" board members were thus de facto excluded from decision-making that went on over business lunches at clubs or at other social events where elite board members came into contact with each other. Furthermore, the presence of these "out-group" members at board meetings changed former patterns of boardroom behaviour, made decision-making lengthier and more controversial, and was seen as potentially threatening to the administrator's power. In an effort to preserve some of the former informality and ease of decision-making and to limit the participation of new board members who were seen as threatening to the status quo or merely as nuisances, the administrator and his elite executives found themselves conducting more and more business outside of the formal

board system. In these institutions, as also in others, decision-making would appear to have become *more* exclusive than before Bill 65 rather than the reverse as intended.

Organizational Control

These three cases suggest that the democratization of boards may have made it more difficult for hospitals to resolve their organizational difficulties because it tended to reduce the boards' control over their members and over the medical staff, and at times, because it weakened the organizational control of the administrator. Organizational control, however, was a double-edged sword: it was an important element of leadership, particularly in times of organizational crisis, but it was also an instrument of oligarchy. Thus, at the Western Hospital the presence of "new" members on the board was a crucial factor in the final collapse of the extreme and repressive control of the first administrator. At the same time, however, the new board structure made it more difficult for his successor to resolve the hospital's problems by hindering his efforts to establish a satisfactory authority relationship with the hospital's staff.

Similarly, at the Rivertown Hospital, the democratized board was a factor in the board's indecisive and conflictful response to financial crisis, but it also helped to weaken the control of an unpopular and many claim ineffective administrator and permitted important inputs to decision-making from the

medical staff.

Democratization, then, had both inhibiting and liberating effects on the hospitals' administrative leadership: it facilitated the break-up of repressive control structures but it also appeared to increase conflict and reduce the speed of decision-making during times of organizational stress.

Participation of Elites

A third observation that can be made from these case studies concerns the effects of board democratization on the participation of community elites. At the Western and Rivertown hospitals, elite board members were confronted by a significant change in the traditional nature of board work. Membership had fewer social inducements for elite participation. Rather than an agreeable pastime in the company of friends and a social showcase for the pursuit of career goals, board work became for some a strained and frustrating experience with risks of negative rather than positive publicity. A few elites in my study resigned from their positions and several others stated their desire to do so.

> People aren't going to want to get on these boards anymore. All you get in thanks is a lot of flak. (BM A)

One factor behind such attitudes was the increasingly "public" nature of board work since democratization. Hospital boards were no longer the private preserve of community elites. What

went on in boardrooms had the potential of becoming "public" knowledge. In studies of secrecy both Rourke (1961) and Shils (1956) have noted that confidentiality was essential to the acquisition of such organizational resources as clients and personnel. For example, applicants for jobs, particularly senior positions, would not apply if the evaluation of candidates were publically debated. The findings in these studies support the notion that elites might want to withdraw from hospital board work because they perceived confidentiality to be a problem in the new board structure.

Another factor in the disenchantment of some elites with hospital board work may have been change in the public image or meaning of such volunteer work. Although a number of incentives underlay elite participation in hospital boards (see Chapter IV), the formal or "public" motivation for such involvement was philanthropic, an expression of noblesse oblige or "public spirit". In the context of Bill 65 and the ideology of participation in the 1960's and 1970's, such volunteer activity on the part of the upper classes took on a connotation of vested interest and power-seeking. A number of my elite respondents expressed distaste for this altered public image.

At the same time as certain aspects of board democratization discouraged the participation of some elites, other aspects functioned to *encourage* it. The successful mobilization of hospital "supporters" at election time was a manifestation of the elite community's continued desire to sustain its

traditional institutional involvements. In a discussion of the solidarity of communal groups, Stinchcombe (1965) suggests that organizations are central to group experience and are integrating mechanisms. Organizations function to represent particular social or cultural groups; the fate of the organization is interpreted as the fate of the group. Traditional hospital boards were elite institutions that symbolized the leadership role of the elite community. As Stinchcombe's analysis suggests, the fate of these boards may have represented to the elite community their own fate, hence eliciting their support in times of threat.

> The feeling is that we'd better be involved or they (government) will just run the place like they run other bureaucracies. (BM P)

This quotation reflects the sense of group consciousness that linked elites to hospital work. The elite community rallied to the cause to defend the integrity of "their" institution and, symbolically, of their own social group.

There was also some suggestion that reorganization functioned to revitalize elite participation.

> Things have changed a great deal. For the better. People (board members) are much more involved and interested. You get far less of the kind of people who were on there in a detached sort of way. (BM V)

It is possible that reorganization screened out the "dead wood" by discouraging the involvement of the less committed.

> They asked X (elite BM) to go on the new board but he wouldn't have anything to do with it. He was afraid the militants would start calling up at midnight with complaints. (BM K)

Or, reorganization may have favoured the "natural selection" of the most interested and capable individuals.

> . . . the Bill has meant that much more effort has gone into the selection of board members. The proper selection. (proper?) Yes, *trying to get only people who really will have something to contribute and are willing to work.* They're not going to waste their positions on sitters. (Dr. D)

Summary

Brief case studies of three hospitals illustrate many of the points made in earlier chapters. Although there was only limited evidence suggesting that the new boards influenced the outcome of decision-making (such as the ousting of administrators at the Western and Rivertown hospitals), the *process* of decision-making and the nature of traditional board work did undergo change. In particular, these three examples suggested that decision-making shifted outside the boardroom as the administrators and their former board advisors tried to recreate the atmosphere that had characterized the former boards, to avoid the administrative "nuisance" of what they saw as ill-informed and divergently experienced newcomers, and, at times, to avoid the involvement of those who were perceived as a threat to the existing administration. It also appeared that

democratization had both positive and negative implications for the leadership capacity of the boards vis-à-vis the institutions they headed. And, finally, reorganization has simultaneously discouraged and fostered the interest and participation of the community elite.

PART IV

DISCUSSION

CHAPTER IX

THE PERSISTENCE OF THE ELITE BOARD MODEL

This final chapter uses the empirical analysis presented in the last few chapters to reflect on the question of why the elite board system has persisted over time and even to a large extent survived an explicit state attempt at democratization. In more theoretical terms than in the preceding chapters, I look at the social significance of the elite boards and at their functional relationship to the hospital and the community. In other words, I try to account for their continued presence in hospital administration in terms of their significance for hospitals and their relationship to broader social structures. Five arguments are relevant to this discussion: institutionalization, organizational uncertainty, organizational need, organizational oligarchy, and class structure.

Institutionalization

Stinchcombe (1965) has noted the historical persistence of organizational forms in general. That is, he has found that the original structure of an organization tends to be perpetuated over time and traces of it can be detected many years after the disappearance of the environmental pressures that initially produced such organizational features. Although his attention

was not primarily on the reasons for the persistence of organizational forms, Stinchcombe suggests that institutionalization and vested interest are two possible factors.

The resilience of the elite hospital board model in Quebec's anglophone hospitals can be seen from this perspective. That is, I argue that the elite board structure persisted because it became institutionalized. By "institutionalized" I refer to two phenomena. First, hospital board work has become, over the years presumably, a social *role*, a repertoire of behaviours and practices with a definable social structure. Members behaved in consistent and predictable ways, shared values and beliefs, and were guided in their role as board member by group norms. Board membership entailed social "rules" on who was asked to join, how members were asked, how they were to respond to the invitation, and how they were to behave once they joined the board.

The second aspect of "institutionalization" refers to the systematic *linkage* of an organizational form to other institutions in the society. Thus, the elite hospital board structure became institutionalized by becoming tied into other elite institutions and other community organizations. For example, as a testing ground for aspiring executives, hospital board work became linked to career strategies of members of the upper class community and to organizational strategies of business and professional enterprises.

Closely related to the linking of the elite board model

with other social institutions is the notion of vested interest. Board work performed functions for both individual members (e.g. retirement careers, job advantages, prestige) and for such other social structures as the community's upper classes (e.g. the training of leaders, the control of community organizations). That is, the institutionalization of the elite board system gave a number of social groups and organizations an "interest" in it.

The institutional character of the elite board system and the vesting of interests in this structure probably contributed to its tenacity historically and during reorganization by giving it a life of its own, as it were, that sustained its social shape somewhat independently of changing hospital "needs" or other social conditions that, many authors would argue, urge organizational forms to change (e.g. Pfeffer, 1973; Burns and Stalker, 1961). For example, even when the original financial importance of elite boards was reduced by third party financing, the elite model remained largely unchanged because it was sustained in part by its latent value as an upper class institution. Similarly, during reorganization, the ability of former elite trustees to remain in control was clearly associated with such "institutional" features of traditional boards as the cohesion and organization of members and their internal normative control.

Organizational Uncertainty

A second approach to accounting for the persistence of the elite board structure is through the notion of organizational uncertainty. A major source of organizational uncertainty noted in the literature is the environment in which organizations are embedded. Organizations are seen as dependent on the environment around them for resources, clients, buyers, workers, financing and so on and their internal structures reflect this dependence (e.g. Buckley, 1967; Lawrence and Lorsch, 1967; Woodward, 1965). This approach to organizational structure and process has also been applied to boards of directors. Boards have been found to "mediate" between the organization and the environment, particularly through the acquisition of those external resources which the organization needs (e.g. Pfeffer, 1973; Zald, 1969; Harkness et al., 1963; Price, 1963; Parsons, 1951). The literature has stressed in particular the boards' function in securing financial resources and generating "community support".

Organizational studies have also pointed to the relationship between power and organizational uncertainty (e.g. Perrow, 1970; Zald, 1969; Crozier, 1964). Crozier, for example, suggests that organizational power adheres to those individuals who have control over areas of uncertainty in organizational processes. In his study of a tobacco company, the maintenance crew were responsible for the upkeep and repair of the machinery

upon which much of the industry's daily work was dependent. Because the smooth operation of this machinery was a source of uncertainty on the production process, the maintenance crews could exert power over other occupational groups and the management.

Combining these arguments and applying them to the case of Quebec's hospital boards, one could propose that the persistence of the elite board structure was related to its capacity to acquire financial support, a major source of hospital uncertainty. The argument would be that boards continued to be the preserve of the community elite because elites were better able than others to provide for the hospital's financial needs (Belknap and Steinle, 1963; Elling, 1963) and because their ability to reduce this source of organizational uncertainty gave them internal organizational power.

One could challenge the uncertainty argument by reversing it. Rather than conceiving of power as a consequence of control over "uncertain" (Crozier, 1964) or "critical" (Perrow, 1970) areas, the "right" or capacity to be influential in important organizational areas may be a function of an individual's or group's position of power in the organization. In the case of hospital boards one might argue that elites had control over much financial decision-making because they were powerful individuals, and not that elite board members had power within hospitals because they filled important economic functions. It seems to me, however, that power and critical

duties are interdependent and do not proceed or follow one another. Access to certain key organizational activities may initially have been a consequence of a group's power, but the performance of these duties subsequently plays a role in perpetuating and legitimating this power. Thus elites may have had access to hospital boards because they were individuals with power, but once there, the fact that they performed key organizational functions was central to their position in the power structure.

The uncertainty argument could also be criticized for failing to account for why elite hospital boards continued to thrive after the provincial government appropriated the board's traditional economic role in hospitals. Indeed, the major source of uncertainty for hospitals has become the government's Ministère des Affaires Sociales and there is little evidence, particularly in anglophone hospitals, that elite boards were especially well-suited to or adept at negotiating with provincial health authorities. In response to this I would argue that uncertainty can be the original source of a group's organization power, but, once acquired, power ensures its own perpetuation. Elite hospital boards were initially sustained by their financial indispensability for their hospitals. Once in place, they became institutionalized, as I have just been discussing, and acquired the capacity to maintain themselves independently of their original economic significance.

It should be noted, moreover, that the notion of organi-

zational uncertainty need not be restricted to an organization's most critical problem. The budget of a hospital may be its most important concern, but it does have to handle other forms of organizational uncertainty. Thus I propose that elite hospital boards, although deprived of their essential role in financial solvency, continued to be an organizational asset by virtue of their ability to reduce other kinds of uncertainty. For example, as I discussed in Chapter V, one internal source of uncertainty for hospitals is the potential power of their boards. As the highest organizational authority, boards have the legal right to wide-ranging control over their hospitals including the hiring and firing of the administrator and appointments of the medical staff. Although boards do not habitually exercise their full powers (Mace, 1971; Vance, 1964), their potential for doing so remains a source of uncertainty for senior hospital personnel. For both physicians and administrators, an elite board membership functioned to reduce the uncertainty inherent in the situation. The behaviour of elite trustees was predictable: they could generally be relied upon to control their fellow members, to go along with executive or committee decisions and so on.

A further source of organizational uncertainty, particularly for administrators, was the hospitals' medical staff. The literature has often documented the difficulties associated with professionals working in bureaucratic organizations (e.g. Kornhauser, 1962). In the hospital setting, one of the

most problematic aspects of the administrators' job is how to manage a quasi-autonomous and professionally powerful medical staff. Elite boards, as I have demonstrated in Chapter V, helped administrators control physicians. Physicians cooperated with certain administrative demands because they perceived the boards' authority as legitimate. This legitimacy in turn rested on such factors as trustees' high social status, their non-threatening yet relevant expertise, and their deference to professionalism.

My data offer a number of other examples of how elite boards functioned to reduce organizational uncertainty. Consider for example, the situations cited in which trustees initiated and arranged deals with certain community agencies whose cooperation was needed by the hospital. Such activities depended upon the fact that many trustees held multiple leadership positions at one time or were acquainted personally or through business with the leaders of the institutions with which the hospital had to deal.

In sum, then, I am suggesting that the reduction of uncertainty was a major function of elite boards and contributed to their persistence up to and after reorganization by rendering them valuable to the two chief powerholders in the hospital, administrators and physicians. Elite boards reduced uncertainty because they could generally be relied upon not to usurp undue organizational or professional power, because they were instrumental in the administrators' control of the medical

staff, and because they helped their hospitals manage external environmental constraints. In contrast, the new boards appeared to create rather than reduce uncertainty. Many of their new members were perceived by administrators and physicians as less predictable and "reliable" because of such factors as high turn-over, open elections, less interpersonal normative control, union involvement and problems of confidentiality. Administrators could no longer be certain what their boards would be like or how they would behave. Moreover, status inconsistencies and a decline in the legitimacy of the board vis à vis physicians reduced the sense of security the boards had previously given administrators.

Organizational Need

A third argument for the persistence of the elite board model and one that is closely related to the discussion of organizational uncertainty is the notion of organizational "need." It has been argued in the literature that the power and function of boards are related to what their organization "needs" for maintenance and development (Pfeffer, 1973; Zald, 1969; Perrow, 1963). A number of studies have found that hospitals with elite boards have tended to be more "successful" or "effective" than thosewith fewer connections with the community leadership structure (Pfeffer, 1973; Blankenship and Elling, 1971; Belknap and Steinle, 1963; Georgopoulos and Mann, 1962).

One way of accounting for this relationship and for the persistence of the elite system over time and after Bill 65, is to reason that elites were the best equipped to meet important institutional "needs." Financial security and, to a lesser extent community acceptance, are two examples of organizational "needs" that elite boards have provided their hospitals (Blankenship and Elling, 1971; Elling, 1963). In addition, elite boards supplied hospitals with "free" high-calibre legal, financial, business and other management advice of obvious importance to large-scale, complex organizations.

My research, however, suggests that the organizational "need" argument has some important limitations. Organizational "need" is not an immutable organizational fact that exists independently of the board of directors. Indeed, the boards in my study appear to have played a central part in the definition of what hospitals "needed" from their environment. For example, the traditional emphasis on capital development created a "need" for funds which was best met by a board with access to community money; hence the elite membership. The emphasis on capital development, however, was in part established and maintained by a board made up of individuals who identified closely with a business and industrial ethic favouring such development.

Similarly, board member recruitment was conducted in part on the basis of the hospitals' "need" for business and professional expertise. These "needs," however, reflected the

interests and orientations of the elite board members as much as they represented any "objective" organizational requirements.

One must be cautious, therefore, of adopting an overly functionalist perspective of the operation and composition of boards because they fulfill "needs" they themselves defined or approved. In my hospital boards, these "needs" were a reflection of or consistent with the upper social class character of the trustees, and they necessitated the perpetuation of such a character. Similarly, the link noted earlier between the high social status of trustees and organizational "success" cannot be attributed uncritically to board members' superior ability to fulfill institutional "needs." For example, the literature often measures "success" in terms of *growth* (Pfeffer, 1973) a goal the boards of directors have set themselves up to achieve. Would the link still exist, for example, if "success" were evaluated in terms of such quality of care indicators as accessibility, continuity or sensitivity to community needs?

Organizational Oligarchy

A fourth perspective on the resilience of the elite board system is the notion of organizational oligarchy. Michels (1949) has suggested that oligarchy is a constituent feature of organizations. Organizational and technical needs favour the centralization of decision-making and create the social conditions that concentrate power in the hands of a few. To

survive, an organization needs to have hierarchy, but those at the top become indispensable as they develop expertise and can manipulate the rest of the organization through controlling information and other techniques. Moreover, leaders come to like their positions of power, and are reluctant to be replaced. Michels concludes that the possibility of democratic decision-making in organizations is probably an "illusion."

An important premise of Michels' argument is that organizational and technical needs *require* the concentration of decision-making. This deterministic relationship is noted frequently in the literature. Navarro, for example, suggests that oligarchy is necessitated by the ideology of industrialism.

> . . . productivity, efficiency, progress and modernization are the components of the intellectual philosophical construct of the ideological building of industrialism. Basic requirements of that construct are the need for hierarchy and dependency within those hierarchies. At the top of the hierarchy is the expert. (Navarro, 1975b:352)

The leadership structure of hospitals supports such theories of oligarchy. As I have discussed in Chapter II, hospitals have strict division of labour, a high level of status differentiation, and multiple hierarchies in which power is concentrated at the top in the hands of professional experts. Although boards of directors are situated at the top of the organization chart, their power and function are dependent upon the nature of their membership (Zald, 1969; my data). The former elite model exemplified many of Michels' and

Navarro's points: board members were "experts" in the major ideological components of industrialism (e.g. business and financial efficiency) and this expertise helped to legitimate their authority in the hospital. The persistence of the elite structure, then, may relate to its ability to provide the kinds of skills to which the forces of organizational oligarchy and industrialization award hierarchical supremacy.

But the expertise of the elite boards was not the only factor in their ability to retain an elite composition. Perhaps even more than *technical* capacity, elite boards had the *social* capacity to compete for power within the hospitals' leadership structure and to avoid being merely "passive instruments of management" as Galbraith has characterized industrial boards of directors (Galbraith, 1967:159). One factor that enabled elite boards of directors to claim power was the social organization of the elite system. Hospital board work, as we have seen, was an elite institution whose social structure and historical traditions provided elites with role models for participation, "motivated" them to participate, and offered them access to and training in such work. This social organization enabled elite boards of directors to function within the administrative triangle as an "institutionalized opposition," the social sub-group Lipset et al.,(1956) identified as a prerequisite to democracy in union management. That is, the organized and institutionalized nature of elite boards contributed to their ability to compete with administrators and medical

chiefs for organizational control.

A second factor in the elite boards' access to power in hospitals was their mediating function between administrators and doctors. I have noted that the personal social links between physicians and elite board members affected the administrators' ability to control the information reaching the board and hence limited the formers' control over decision-making. At the same time, however, we also observed that elite boards buttressed the control of administrators over their medical staff. Elite boards thus performed an important political function within the "negotiated order" of the hospitals' leadership triangle. In this sense elite boards functioned to diffuse organizational power, preventing its concentration in the hands of either the doctors or the administrators.

In sum, then, I am arguing that the notion of oligarchy helps account for the persistence of the elite hospital board model in two ways. First, the technical skills possessed by elites and their institutionalized social structure--two elements of the theory of oligarchy--enabled them to claim and retain organizational power in the hospital. Second, hospitals are characterized by multiple oligarchic hierarchies whose leaders (administrators and senior medical staff) were engaged in continuous competition for organizational control. Elite boards functioned as fulcrums in the distribution of power between two hierarchies; they were used by both in their attempts to maintain or strengthen their organizational positions. This

political function of elite boards gave administrators and physicians a vested interest in supporting the existence of the elite board model.

Application of this argument to analysis of the *new* boards casts perspective on why reorganization failed to introduce major change into hospital governance, which, of course, further accounts for the ability of former elite board members to retain control. First, new board members, by and large, lacked the skills favoured by organizational pressures to oligarchy. That is, many newcomers were not attributed the technical skills that supported the elites as board members and justified their authority. A second and related factor in the inability of new board members to claim a legitimate place for themselves in the hospital power structure was their lack of the social capacity to mediate between administrators and physicians. They were not seen as possessing the expertise, social status, impartiality, and professional deference that were attributed their elite predecessors and that underlay their organizational authority. Thirdly, unlike elite trustees, most new board members were not supported by a social structure that encouraged and facilitated participation. They had no organized reference group, no role models and no group norms to initiate, organize and support their performance as trustees. It is noteworthy that the union's initial attempts at bolstering the strength of "their" board members consisted primarily in trying to provide the social structure and support that was

such an important element in the elite's hold on hospital power.

Class Structure

In this chapter I have discussed four concepts that are relevant to understanding why the elite board model has persisted over time and largely survived "democratic" reorganization by the provincial government. All of these concepts are closely tied to a further concept that deserves explicit consideration: *social class*. I would like to argue here that the nature and functions of elite hospital boards and the process and outcomes of "democratization" depended mainly on the class structure of society.

Social Class and Board Reorganization

The nature of traditional hospital board work was clearly linked to social class structure. Its institutional character was distinguished by the relationship between board work and the shared upper class status of trustees. We saw, for example, that board membership was an insignia of upper class affiliation, that it provided an outlet for class-generated perceptions of social obligation, and that it offered latent career and social mobility benefits. Recruitment was heavily based on social class considerations, and internal social control was affected in part by virtue of external social status (also in Blishen, 1950). Because hospital board work was tied

in to broader social structures in these ways, former board members had a vested interest in the traditional board structure and were prepared to defend these "stakes" (Fox, 1971) when democratization was imposed by the government. Furthermore, by virtue of their organization, internal cohesiveness, external occupational positions, superior access to information and expertise--all related to their position in the class system--traditional board members were in a key position to influence the make-up and operation of the new boards.

The organizational functions of the former elite boards also depended upon the social class of their members. For example, among the "external" functions of elite boards was the acquisition of certain material and social resources. Domhoff (1971) and Hunter (1953), among others, have shown that leaders know other leaders and have access to each other by means of such class ties as school, club, and intermarriage. This interconnectedness of institutional leadership facilitates leaders' ability to secure resources for their organizations (e.g. Moss et al., 1966; Elling, 1963; Belknap and Steinle, 1963). The social "symmetry" of elite hospital boards with other community leadership structures arose at least in part, from the fact that board work was an upper class institution which favoured the continued selection of individuals with overlapping leadership commitments.

The "internal" functions of elite boards were also associated with class structure. For example, the organizational

"efficiency" of elite boards that administrators valued arose from board members' internal normative agreement, interpersonal trust, informal patterns of interaction, self-regulation and so on, all of which depended upon internal social homogeneity and the shared class membership of trustees. In addition, such attributes as executive "posture," and belief in managerial autonomy were carry-overs from the outside executive experience of board members, again a consequence of the fact that trustees were predominately from a social class disproportionately represented in executive organizational positions. In other words, the attributes of elite board members that administrators most appreciated were ones that were directly linked to the members' social class status.

Social class was also a major factor in the second and more important "internal" function of the former boards: their mediation of power relationships between administrators and the medical staff. Physicians perceived traditional board members as their status equals and were consequently willing to concede them certain authority in the hospital context. Physicians also recognized the authority of elite board members because, belonging to the same social class, they shared common values and interests with them. For example, most of the physicians and board members I interviewed expressed similar or compatible beliefs on the technological development of the hospital, the importance of professional autonomy, and the legitimacy of expertise as a basis for power.

In this section, then, I have proposed that the link between the nature and function of traditional hospital boards and the social class structure of the broader society was central to the process and outcome of board reorganization under Bill 65. First, the institutionalization of board work as an elite enterprise made the "old" boards particularly unwilling to be displaced and put them in an advantageous position to maintain the traditional system. Secondly, the organizational functions of elite boards, such as their provision of political and financial resources, the compatibility of their orientations and behaviour with those of the administrator, and their role in the management of the hospitals' medical staff, generally ensured the support of the administrator and the physicians, which in turn contributed to the relative failure of the legislation to alter the locus of control within Quebec's anglophone hospitals.

In other words, the "democratization" of anglophone hospital boards had limited and unanticipated consequences because:

(1) The former elite hospital boards were perceived by administrators and the physicians as being more able than their democratized alternative to meet the hospital's organizational needs. Because former board members belonged to society's upper class, they had better access to resources, more control over certain contingencies in the hospitals' external environment,

and more authority over hospital professionals than the new non-elite board members were presumed to have. Administrators and senior medical staff thus had an interest in retaining the elite system and actively participated in its preservation.

(2) The relationship of traditional hospital board work to broader class structures enhanced the willingness and ability of elite board members to resist democratization and to maintain effective control.

Thus, a major determinant of the outcome of reorganization has been the social class structure of the society in which such change was attempted. Because democratization violated class hierarchy the new board structure was inconsistent with the "inner logic" (Navarro, 1975a:124) of the system. Non-elite trustees were incongruent with outside leadership structures, were unable to retain the organizational authority necessary to compete for power within the hospital itself, and had less incentive, organization and power to compete successfully with their predecessors. This conclusion, although limited to a specific instance of hospital administration, is consistent with and gives certain empirical support to Navarro's assertion that,

> The deprofessionalization of medicine, and the dehierarchicalization of medicine, i.e. its democratization, are not possible within our class-structured society. The change of the latter is a prerequisite for the change of the former. (Navarro, 1975b:358)

The Perspective of Class Structure

This analysis of the significance of social class structure for the nature of the old boards and on the outcome of reorganization makes several points of relevance to the literature on the control of health institutions.

Illich (1975), in his assessment of the roots of the "crisis" of our medical care system, argued that the professionalization and bureaucratization of medicine has generated disease, made individuals overly dependent on medical care institutions, and encouraged the medical expropriation of social problems. Navarro (1975b) criticized Illich's analyses on the basis that it is not industrialism (and its symptoms, professionalism and bureaucracy) that are the compelling factors in the current health care situation, but capitalism, and the class system of society.

> . . . by focussing on the medical bureaucracy as the 'enemy,' Illich misses the point because those bureaucracies are the servants of a higher category of power that I would define as the dominant class . . . . Indeed, the empirical analysis of the health industry shows that . . . it is administered but not controlled by the meidcal profession. . . . Indeed, those who have the first and final voice in the most important 'corridors of power' in the health sector are the same corporate groups that control and/or have dominant influence in the organs . . . of production, . . . and members of the upper middle class (executive and corporate representatives of middle size enterprises and professionals, primarily corporate lawyers and financiers) have dominant influence in the (health delivery) institutions. (Navarro, 1975b:357)

Navarro does not, however, cite the empirical support he claims

for his interpretation. The argument for class hegomony is, in general, only scantily substantiated in the literature. We appear to know particularly little about the *process* of elite control. Being told that a certain social "class" has "dominant influence" in the "health sector" does not tell us who these individuals are, what the nature of their influence is, or over which health care institutions they have control.

Hospital boards of directors are a good example of upper class presence in hospital decision-making. The high status membership of these boards does not, however, *in itself* indicate institutional control by an elite class, an assumption apparently made by Navarro. A similar begging of the question that is frequently made in the literature is that boards of directors, by virtue of their hierarchical position, are inherently powerful administrative bodies. My research suggests that not all boards are equally influential in the organizations they head, and even among boards with an elite membership, their organizational significance varied considerably. The effective power of elite boards appeared at least in my limited sample, to reflect the degree to which the board approximated the ideal type. Thus, for example, connections to outside leadership structures and to financial support were generally not enough in themselves to give a board intra-organizational influence. Such other characteristics as the social cohesiveness and institutional identification of the membership were needed at the same time for the board to achieve its full power potential.

The ideal typification of the elite board system thus documents one instance of the upper class "control" to which Domhoff and others refer and points to those social characteristics that underlie variation in such control.

Navarro (1975b) goes on to suggest that the power of the medical bureaucracy, the focus of Illich's analyses, is only *delegated* to it from the corporate and upper middle classes. Freidson's conceptualization of "professional dominance" also recognizes this delegation of power.

> A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society. (Freidson, 1972:72)

Neither author, however, describes the nature of this delegation. What kind of power is conferred upon the medical profession? What is the relationship between the "upper class" and physicians? My study provides certain insight into this power-sharing arrangement. I have shown, for example, the "symbiotic" relationship between the former elite hospital boards and the hospitals' medical staffs; the former give the physicians autonomy and financial support in return for compliance with certain administrative/organizational needs. This cooperation is fostered by a mutual recognition of authority which in turn rests on their common class interests and institutional *Weltanschauung*.

I do not think, however, that Navarro is entirely correct in dismissing Illich's issue of professionalism. Elites do acquiesce to professional prerogative calculated reasons

("You've got to handle these guys (doctors) carefully or they'll never cooperate!" BM W), but they also do so because they believe in the medical profession's inherent *right* to such prerogative. I would argue that although professional power may originate in the "dominant class" (i.e. the upper classes delegate power to the doctors), the professions then generate their own power (the ideology of professionalism) to which the upper class adhere like everyone else.[1]

My analysis raises some further issues in relation to Navarro and other Marxist sociologists. Underlying many of Navarro's arguments is the presumption of *conspiracy;* his style and general tone of writing often implies conscious and sometimes malevolent design on the part of the dominant group. Consider the following examples.

> . . . service bureaucracies--including medicine--are, far from failing, succeeding in what they are *supposed to do* . . . (one aspect of which is) to legitimize and protect the system and its power relations. (Navarro, 1975b:358)

> . . . both the distribution of skills and knowledge and the control of technology *are aimed at* strengthening class relations within the health sector. (Navarro, 1976b:208)

Navarro implies, with little empirical substantiation, that the corporate class has political self-awareness and explicit

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[1]The deference of hospital board members to professional independence has been frequently noted in other studies. See for example Harkness et al., 1963; Price, 1963; Kovner, 1974a, 1974b.

objectives of social dominance. Dominance, certainly in current social contexts, has a pejorative connotation. In the light of my own research, I find the insinuation of conspiracy inappropriate and distorting. One has to distinguish between the *objective* and the *subjective* dimensions of social action. Objectively, the system may well operate to maintain class dominance, but to attribute participants with intent and subjective awareness is to confuse social reality with political analysis. For example, I have pointed out that expertise was not the only or even the most important recruitment criterion in elite hospital boards. The stress on expertise was, to some extent, a legitimating ideology that arose from the tendency of elites to deny the existence of social class differentiation (Domhoff, 1971). This, however, is not to suggest that board members themselves did not genuinely believe that expertise was the basis of their recruitment policy. In the same way, most of the elite board members I studied did not appear to be trying to "hold on to power" or to "protect class interests," although that may in fact have been the consequences of their action. Basically, they were trying to ensure that the hospital had what *they considered* to be an effective board which could continue to perform in the way *they* felt was right and appropriate. Naturally, of course, they perceived the traditional model to be satisfactory and tried to shape the new boards in their image.

In other words, although elite participation in hospital

boards may have functioned to further class interests, such was not necessarily the intent of individual board members, most of whom perceived their own involvement as a personal life strategy. This is not to say that these personal strategies are not rooted in class structure, but only that "class" is often expressed empirically in individual terms.

In these ways I feel Navarro's critiques, while probably valid on a certain analytical level, fail to appreciate the social-psychological reality of the social action he observes. His focus on political outcome leads him to attribute inappropriate meaning to the social processes concerned.

In summary, then, my analysis of hospital boards relates to some of the literature on the control of health institutions. At the same time as it provides some empirical data for Navarro's theoretical propositions on the control of the health sector by the upper class, it also suggests that his conceptualization of control obscures and sometimes falsely portrays what is happening at a more micro-sociological level.

Implications of the Class Dimension of Hospital Boards

By assembling various points made throughout this study, an attempt can be made to assess some of the consequences for hospitals of the link between social class structure and the function of their boards of directors.

One assessment of the former elite hospital boards might be that they were advantageous organizational adaptations to

the environment in which hospitals have to operate. Given the structure of society as it is, elite boards were well equipped to secure such important organizational resources as money, inter-organizational cooperation and other political trade-offs. In addition, such boards could provide high-quality organizational expertise that helped hospitals cope with the large size and complexity of their operations. Elite boards were also able, as we have seen, to exert some degree of control over physicians who are central to the nature of the health sector and to its capacity to change. Moreover, elite boards, by virtue of their internal social organization, were often able to provide hospitals with an organized, consistent, and reliable board membership, one that was encouraged by its own internal dynamics to furnish an amount of commitment and effort that has not been widely achieveable in other volunteer participation situations (e.g. Jaworski, 1972).

An alternative assessment, however, points to the organizational *disadvantages* of many of these same elite board attributes. Elling (1963), for example, describes an instance in which too great a dependence on an elite board of directors lead to the closure and merger of two hospitals against the wishes of their staffs. One can also argue that despite the obvious relevance of certain elite board member skills, the *range* of the expertise of an all-elite board was limited by the fact that members came from the same or similar social milieux. Thus, for example, elite boards were more oriented to techno-

logical and administrative issues than to, say, problems of community health (Kovner, 1974a, b; LeRocker and Howard, 1960), and their personal medical experiences were confined to "private" wards of floors.[1] In other words, elite boards represented only one community value pattern, and one that was not necessarily shared by the majority of the hospital's users. Harkness et al. (1963) observed that their elite hospital boards behaved on the basis of values that were unconnected to hospital goals; board members were more concerned about their own roles in the community than about such hospital objectives as quality of care or fiscal soundness.

The social organization of elite boards also had certain negative implications. The competitive relationship between hospitals and between their boards may have encouraged trustee involvement and participation, but it also discouraged regionalization and inter-organizational collaboration. For example, the hospitals I studied had a history of resistance to such joint ventures as group purchasing and to the centralization of certain underutilized facilities. Similarly, although elite boards may have been able to exert control over physicians, the basis of this control lay heavily on the trustees' deference to professionalism which, as several authors have

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[1]Even after the introduction of hospital and general health insurance, patients and wards continue to be distinguished as "private" or "public" depending on the patients' connections to the hospitals' attending staff.

observed (e.g. Kovner, 1974; Zald, 1967; Elling and Lee, 1966; Harkness et al., 1963), have led trustees to abrogate their responsibilities towards such basic issues as the nature and quality of medical care.

Summary

This chapter has tried to reply to the question: why has the elite hospital board model persisted over time and emerged relatively unscathed from the Quebec government's attempt at democratization? Five arguments were used in accounting for the resilience of elite boards. The first included the notion of institutionalization: the fact that elite boards were organized social systems closely tied in to broader social structures gave members a vested interest in the system and the ability to protect and perpetuate the structure as it was. Secondly, the elite board model was defended by hospital administrators and physicians because it helped reduce certain organizational uncertainties: elite boards could be relied upon not to usurp undue administrative or professional power, they were used by administrators in their efforts to control their medical staffs, and they helped their hospitals manage certain environmental constraints. Thirdly, although it was noted that the concept of "organizational need" is a social construct, elite boards were strengthened by their ability to furnish their hospitals with skills or knowledge that the hospitals

required to survive and/or develop. Fourthly, the theory of organizational oligarchy helps account for the persistence of elite boards: the technical skills and institutionalized social structure of elite boards enabled them to claim and retain organizational power and to play a part in the distribution of control between the administrative and medical hierarchies. And finally, I have noted that the relationship of elite boards to the broader social class structure of society has been a major factor underlying their function in hospitals: elite boards were consistent with the class structure of the society in which hospitals are embedded and this consistency supported the boards' position of power in the hospital and contributed to their persistence as an organizational form.

In general, my argument is a functionalist one whereby I account for an observed phenomenon in terms of the purposes it serves for some social system. The elite board model has been resilient to change because it has been "functional" to hospitals and to those people within them who are in positions of power. In other terms, administrators, physicians and elites themselves have had few incentives to alter the elite board system because it served their interests well. Those who might not have been as well served by the elite board system and the kind of hospitals it supported (possibly the poor and the chronically ill, for example) were not in a position to exert any impetus for change in board composition. Even the State, which in Quebec has become the major locus of power in the health

sector, had only limited success in democratizing hospital administration.

The analysis leads to conclusions that are consistent with Marxist theory. The attempt to democratize the boards of directors of anglophone hospitals in Quebec had little success in rendering hospital administration accessible to a more representative range of social interests because the social structure of society, particularly its class and leadership structure, favoured the former elite system and denied the non-elite newcomers the authority and power necessary to meaningful participation.

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