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The Medical Council in Belgian hospitals: A political perspective

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Abstract

Archetype-theory gained prominence in the literature dealing with the "managerialization" of professional organizations. However, this theory has been criticized. Due to its functionalist legacy it underplays the role of agency in the organizational structure or in its change. Following this critique we develop a political perspective on the relation profession – management. Such a view stresses the interlocking of organization and domination. However, control does not just apply to workers and work, a 'rule by rules' implies rulers are also object of regulation. Agency will be directed at having an impact on rule creation. In the end organizational structure is designed to control the agency of both profession and management. The elaboration of structure is not to be seen as a function of the qualities of work, or of organizational performance. Rather our analysis of the genesis of the medical council in Belgian hospitals suggest that it results out of agency within a specific policy process.

Key words • double closure • hospital • medical council • medical profession • political perspective • regulation

Situating the problem

It has been argued that professional organizations undergo the superimposition of managerial structures over professional activities (Cooper et al. 1996; Farrell and Morris 2003). On this subject archetype-theory, a fusion of contingency and neo-institutional theories, gained preponderance.

From the first it borrows the view that organizations are patterns of relations and the embodiment of a common set of ideas – an interpretative scheme. From neo-institutionalism it takes the idea that these schemes do not 'float in the air' but originate from organizational fields (Kirkpatrick & Ackroyd 2003b).

Working within this paradigm Greenwood and colleagues (1990) proposed the professional partnership (P^2) concept, which refers to organizations 'for professionals by professionals'. However, archetype-theorists argue, environmental factors affected

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the professional organization (Brock 2006), resulting in new archetypes, the managed professional business (MPB) (Cooper et al. 1996) or the global professional network (GPN) (Brock and Powell 2005). Both display increasing managerialism and business values.

By arguing that 'structures and systems … are infused with meanings, intentions, preferences and values' (Brock et al. 2007, 3) archetype-theory emphasizes the role of professional groups' values and agency in the elaboration of organizational structure. It further has the merit that it stresses historical development of organizations. But a series of publications (Ackroyd and Muzio 2007; Kirkpatrick and Ackroyd 2003a,b; Kirkpatrick et al. 2005) indicate its limitations.

A fundamental critique pertains to archetype-theory's focus on functional change. Environmental transformations induce a new archetype more functional within this new environment. Also, it experiences difficulties in handling conflicts and power relations between groups. It recognizes conflicts as long as these make organizational structure come to be better aligned with its environment. Due to its functionalist legacy, it underestimates the role of the actor's agency in organizational structure and its change. Moreover, archetype-theorists focus on for-profit organizations, but quid with non-for-profit or public professional organizations such as hospitals?

Over the last few decades, we have witnessed doctors integrated into hospital-management (Kirkpatrick et al. 2009). For medical sociologists this poses the question of the relation between management and the medical profession. Ong and colleagues (1997) identified here two analytic models. The first emphasizes the increasing (state-sanctioned) managerial power over doctors. The other argues that no professional power was lost, since the medical profession adapted. Both models however are framed within an inherent contradiction between medicine and management.

Recently, scholars presented findings challenging this assumption (Degeling et al. 2006; Filc 2006; Fitzgerald and Ferlie 2000; Jacobs 2005; Kirkpatrick et al. 2007; Kirkpatrick et al. 2009; Kitchener 2000; Kurunmäki 2004; Llewellyn 2001). Rather, they stress a focus on doctors' agency, mindful of national conditions, histories and trajectories either fostering or closing off opportunities for doctors to dominate management work (Kirkpatrick et al. 2007). Archetype's underestimation of agency and power becomes so highly problematic.

To overcome archetype's shortcomings some suggested connecting the studies of organizations and profession, by focusing on conflict and social closure (Kirkpatrick and Ackroyd 2003a; see also Lounsbury and Ventresca 2003). Following this proposition we outline a political perspective on the relation management – profession. Political means the search for a share in power or an impact on its distribution, between states, or within one state between the groups it encloses (Weber 1999). This means that to analyse organizational change and structure one needs to look at the dynamics of an underlying power system (Dion 1982).

Empirically we focus on Belgium. This selection is infused by the necessity to look at the relationship doctors – management in the context of an insurance-based healthcare system (Kirkpatrick et al. 2009). In Belgium, the Royal Decree number

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407 (1986) and the Coordinated Hospital Law (1987) integrated medical activity in the overall hospital's activity. Such integration must be based on professional autonomy and on doctor involvement in hospital-management. This last occurs in two specific ways.

First, individual professionals were attributed management responsibilities; this is specified in the functions of Doctor-Head-of-Service and – especially – the Head-Doctor. This last, as a member of the hospital direction committee, is responsible for the good working of the medical department and for the overall organization and coordination of medical work.

Second, the medical council is the collective organ by which all doctors are integrated into the hospital's decision-making process. It is defined by the law as an advisory body. Failure on behalf of the hospital administrator to consult the medical council may be sanctioned by penal courts. By way of reinforced advice, this council can impose negotiations upon the hospital administrator. This is a safety device aimed at preventing the hospital administrator from ignoring the opinion of doctors on issues that have been legally defined as sensible.

We narrate the negotiations leading to the legal recognition of this medical council, which gives the medical profession an instrument to interfere in hospital-management. Doing this, we do not focus on the NPM reforms. We are not questioning the impact of the reforms since the 1980s. As we argued elsewhere (2009) in these we witness an enhanced organizational reflexivity and a reinforced profession's grip on work. Instead we wish to look at the genesis of this law in order to bring into focus the actors' agency and the question of power.

A Political Perspective on the Relation Organization–Profession

Basically we conceive a professional as a broker who exchanges his knowledge and expertise with an organization. Both, professional and organization, are linked by a relationship wherein they exchange goods and services. Central in this is the concept of work, which is fundamental to both (Abbott 1988; Freidson 2001; Lammers et al. 2000, 27–35; Perrow 1961, 1963, 1965, 1967;). Work can be defined as a set of tasks (Abbott 1988) or as an implementing of all technologies in order to alter energy, information or a raw material, whether personnel, symbols or things (Beniger 1986, 9, 13–16; Perrow 1961, 1963, 1965, 1967).

In order to complete this work an organization needs to coordinate its members and their activities (Mintzberg 1996). This implies that a great deal of what an organization does consists in controlling work (Simpson 1985). We see control here as conscious influencing in order to achieve specified goals (Beniger 1986, 7), with other words as agency steering. Several scholars demonstrated that bureaucracy and professionalism enable such control on work and workers (Beniger 1986; D'Cruz and Noronha 2006; Evetts 2006; Faulconbridge and Muzio 2008; Fournier 1999; Stinchcombe 1959; Waring and Waring 2009).

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Regulation of agency, the rules governing agency and how these are made and implemented (see Moran and Wood 1993), is central. Accordingly, within organizations one will find a legal system, a set of 'norms governing the expectations and actions of the members of a given system', and 'a set of specialized statutes to which are allowed different normative [executive, legislative, judicial] functions' (Evan 1965, 53).

One may assume hence, next to the technical division of labour, a division of rights. These are those 'actors can claim, impose, assume, manipulate for, argue and negotiate over various types of work … This involves rights agreed to or enforceable, given the necessary resources-legal, financial, manpower etc.-for ensuring their institution or maintenance' (Strauss 1985, 9). Just as the division of labour is shaped by power (Freidson 2001, 41), so does this division of rights.

Indeed, organizations are political structures operating by the distribution of authority, setting a stage for the exercise of power (Zaleznik 1970). This makes the question asked by Buchner-Jeziorska and Evetts (1997) fundamental: Who supplies and operates the system of regulation? In the end, then, the question of regulation and control, is related to the issue (and distribution) of power and authority. This means that domination and organization are interrelated (Clegg et al. 2006).

Closure and Double Closure

In order to specify our perspective the closure-paradigm proves helpful. This last argues that professional groups act in ways that make sure that any regulation develops in favour of the affiliated professionals. A powerful tool to this end is the s*ocial closure* mechanism: 'social groups formed around positions in the technical division of labor create social and legal barriers that restrict … access to resources and opportunities to a limited circle of eligibles' (Weeden 2002, 57). By this a professional group seeks an exclusivity in order to create *property* (legitimized ownership) for professionals (see Perkin 2002).

Professional groups can seek to establish a social closure at a societal level. But can we expect it at organizational level? Professional groups, indeed, exhibit a tendency to influence the organization in which they work and to model it according to their own standards (Derber and Schwartz 1988; Mintzberg 1996). In turn, the concept of double closure (Ackroyd 1996) refers to the process whereby a professional group seeks to combine control on the medical market and informal cooperation and control within organizations. In other words, a profession erects barriers to restrict access to resources and opportunities, both outside and inside the organization.

Critiques

The closure-paradigm, dominated by 'a conspiracy' accounting (Buchner-Jeziorska and Evetts 1997, 62), has difficulties in handling notions of self-interestedness and altruism

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(Saks 1995). It gives credit only to the notion of self-interestedness, devaluating any manifestations of professional altruism as merely a 'trick' to lure clients and supporters.

Also, it tends to focus exclusively on the demand-aspect, 'the occupation's organized pursuit of its interest', occulting the supply-side of the story (Dingwall 2004, 7). This paradigm, indeed, focuses on professional autonomy, an aggregate effect of social closure (Flynn 1992, 24). But one finds in the literature indications of that professionals can enjoy a different autonomy (Courpasson 2000a,b; Friedman 1977; Mintzberg 1996, 309–35). One provided by the employing organization and resulting from a managerial strategy, a *responsible autonomy*. In order to obtain the loyalty of workers management gives them status, authority, autonomy and responsibility (Friedman 1977, 6,78).

Autonomy, with other words, can be used as an instrument of control (Courpasson 2000a). Such a finding forces us to avoid the dichotomy power (hierarchy) – resistance (autonomy), which is misleading. Power can resist, and resistance uses power. To escape conceptual dichotomy, and display their dynamic interplay, a fusion of power and resistance is necessary by means of the struggle concept (Fleming and Spicer 2008).

The double closure perspective, as used by us, infers that professional groups can aspire to extend their control out of the core business into management, literally to make the arena of organizational steering their *property*. Doing this, they will enter into a political struggle with the organization's (legal) owner(s) and his (legal) property rights (see Derber and Schwartz 1988).

On one aspect, however, we deviate from Ackroyd's definition. Where he focuses on the 'informal' aspect, we want to look at (written) rule-imposition on organizations. This stance is justified as follows. In order to create an enduring domination a 'rule by rules' is needed (Clegg et al. 2006). Participating in the creation of this 'rule by rules' is advantageous. Professional groups can seek to extent their power by means of (written) rules, which enhance their certainty with respect to theirs and others agency (Alter 1993; Dion 1982). Also, a 'rule by rules' means that the exercise of authority is subjected to rules, and thus to regulatory activity.

To summarize, in organizations there is a structure of domination which by regulation seeks to control agency. But, this structure of domination, which prescribes rules for others' agency, is also subjected to rules. Our political perspective stresses that professional groups, in order to impose a closure at organizational level will initiate a political struggle to influence regulation.

Methodology and Data

Our article is based on the assumption that history and society are formed by agency, which in turn is shaped by history and society. Historical sociology then implies the study of social change (Abrams 1980, 1982). To develop a view of social change one constructs a story, a narrative, of the transition from one defined point to another

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(Abbott 1992; Abell 2004). Such approach is an attempt to understand how things happened in order to understand why they happened (Aminzade 1992; see also Ricoeur 1983).

A narrative unifies happenings by defining these as elements of one and the same story (White 1987). Its central logical structure is provided by the use of a central subject that delivers both unity and continuity to the story (Hull 1975). It is clear that we embrace the idea that it is the researcher who 'constructs the past' (Lorenz 1987).

In order 'to construct' our narrative, we used published sources (magazines of medical unions, and annual reports of the Christian hospital federation) and unpublished sources (archives of medical unions, ministerial cabinets and the Christian hospital federation). In a first phase we used published sources to reconstruct the great steps of the negotiations between the HIS-actors. This then provided us with a better understanding of the unpublished sources. Using these we were able to gain a look at the 'negotiations-in-action' – thanks to the different work-documents, handwritten notes or minutes of the negotiations.

Historical Narrative

1944–1963

By the Decree-Law of 28 December 1944 the Belgian Government installed a compulsory Health Insurance System (HIS). By using a Decree-Law the Government bypassed the parliament and the different pressure-groups, including doctors. As a result, the Belgian Medical Federation (*Fédération Médicale Belge* – FMB, the historical medical union) refused to accept any kind of agreement within the framework of the law.

Further, the FMB was not pleased to see the – politicized – sickness funds gaining an important role, namely being charged with the administration of the health and disability insurance. The strongest sickness funds – the Christian National Alliance and the Socialist National Union – each belonged to a corporatist 'pillar', which both reflects and creates ideological cleavages in society (Pasture 1993).

The problem is that the Compulsory HIS was inherently unstable because the executive power could, by issuing of decrees, change the entire system according as it saw fit. This inherent instability was aggravated by a context of strong tensions between confessional and non-confessional political parties. These tensions hampered the creation of a clear, stable legal frame for social security, and ipso facto for the hospitals.

The introduction of Compulsory HIS meant a social democratization of access to hospital services. In turn, hospitals could only access this new market of insured clients if they were recognized by the State. For this they had to comply with certain criteria and to be approved by a Commission of experts. These hospitals were mainly the property of three great groups: municipalities, religious orders and sickness funds.

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The HIS let these hospitals exist as autonomous care providers. Following ownership lines they regrouped under the umbrella of federations, who act not just as supportive structures but also interest groups. The newly created market caused a huge increase in the total number of patients and led to a strong expansion of the entire health care sector. The central government further stimulated this trend through a policy of subsidies covering the renovation and expansion of hospitals.

With the Compulsory HIS and this expansion, Belgian doctors faced two new situations: on the one hand more work possibilities (Franckson n.d.) and on the other increased internal competition. The FMB was irritated by this. It saw the sickness funds and public hospitals making profits at doctors' expense. Because national agreements between sickness funds and the medical profession about fee-schedules were absent, sickness funds decided unilaterally on the level of the fees which were lower than the amount of money hospitals received by way of the reimbursement.

An angered FMB saw doctors who accepted work under conditions prescribed by the hospitals and sickness funds as behaving 'unethically'. In response, FMB headquarters decided in 1948 to support the principle of co-administration: doctors should be part of the overall hospital decision-making process. Initially, it drafted a 'statute for hospitals and day-clinics', which never mentioned a medical council but expressed a willingness of the FMB to regulate the relation between doctors and hospitals.

After the failure of the statute of 1948 the FMB sought the collaboration of the Sickness-Funds to make its own guidelines mandatory in the Funds' hospitals. In a new FMB text of 1950 there appears a medical council composed of the heads of services. However, due to the refusal of the Sickness Funds to follow the FMB, all of this ended in a dead end.

Finally, by 1952 the FMB concluded that this problem could only be solved as part of a larger reform of the entire Health Insurance program. It was not until the period from 1959 to 1961 that the Union of Belgian Specialists (VBS) and the Christian Hospital Federation (VVI) finally concluded an agreement to create medical councils in Catholic hospitals, which would occupy the highest offices of supervision over medical practice within these hospitals.

1964–1973

Unity between the different Belgian medical unions appeared only during times of external threat. So in 1961 the medical unions founded the General Union of Belgian Doctors in order to contest the Law on Economic Expansion, Social Progress and Financial Recovery. It was in this context that the first Syndical Chamber (*Chambres Syndicales*) was created in 1962, its founders advocating a more aggressive stance ('no more compromises'). In less than a year Syndical Chambers were established all over the country. This was to alter Belgian medical unionism fundamentally.

Meanwhile, ideological tensions between confessional and non-confessional parties were pacified by the so-called Schoolpact of 1958. This paved the way for

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the creation of a law on social insurance, and the first Belgian Hospital Law. The Minister of Social Affairs, the socialist Edmond Leburton, proposed a Law-Project on the reform of Health- and Sickness Insurance. This law sought to improve access to insurance coverage for almost the entire population. Other important elements were: a listing of different medical services ranked by relative value, the 'nomenclature,' and a system of conventions and agreements between sickness funds and health care providers which set prices for medical services and regulated their financial and administrative relationship (European Observatory on Health Care Systems 2000).

In 1963, the medical unions regrouped in a Committee for Common Action in order to fight the Leburton-proposal. Using the cover of this Committee, the Chambers started to prepare a general strike. They also infiltrated other members of the Committee. Eminently successful, in less than four months these other members were dissolved and integrated into the Syndical Chambers in 1964. The Union of Belgian Specialists (VBS) remained independent but closely tied to the Chambers. Only the General Syndicate of Belgian Doctors (ASGB) remained outside the Chambers' sphere of influence.

The adoption by parliament in 1964 of the Leburton-Project was for the Syndical Chambers a declaration of war. They initiated their general strike in protest. Meanwhile, negotiations between the Government and the medical profession led to the Saint-John agreement, also in 1964, which established the autonomy of the profession and its influence within the HIS (Schepers 1995). In any event, the medical profession and Sickness Funds now dominate Health Insurance System policies. The concept of Pax Medica refers to this situation in which both partners 'slice up the national cake' (Schepers 1995).

Concomitant with the vote of the Leburton-Law parliament also adopted in 1963 the first Belgian Hospital Law. This Law's principal themes were the quality of hospital institutions, a solution for the financial viability of hospitals, and guaranteed access for everyone to hospitals. It formulated a planning for the geographic distribution of hospitals. This planning was however indicative, it only applied to those hospitals asking for state-subsidies. It introduced a per diem financing system for each patient day established on the base of the hospital's bookkeeping data. But a backdoor in the legislation implied that the funding by the central government was not to be based on the real needs but on the additional costs which could be proven by the hospital (Sermeus 2003, 13). This placed financial responsibility for hospital costs on the shoulders of the central government (Callens and Peers 2003).

In the aftermath of the 1964 strike it was decided to create a commission to study the regulation of the relation between doctors and hospitals (Prims 1997, 178). In order to facilitate this commission, a so-called Commission De Schouwer was created (from 1965 to 1967). With respect to the medical council, three actors expressed a coherent view on the matter of the relation between doctors and hospitals.

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- Public hospitals wished to restrict the medical council to a pure advisory body without any obligation for the management.
- Syndical Chambers defined the medical council as an instrument for co-management with a binding advisory right.
- The Christian Hospital Federation stated that doctors have a right to co-decide on matters that influence the exercise of the medicine in the hospital; but this right is not absolute, limited to a list of specific items.

The discussions in the De Schouwer Commission paved the way for the installation in 1970 of the National Joint Commission on Doctors and Hospitals. Doctors were represented by the Syndical Chambers, which had a clear numerical superiority in the Commission, and the General Syndicate of Belgian Doctors (ASGB). Hospitals were represented by the Confederation of Cure-institutions, which united all Belgian hospital federations.

For the Syndical Chambers the goal overall is a medical council with a reinforced advice as an instrument of co-management. On the other hand, hospital-federations seek two things. First, they wish to guarantee a place in the hospital for the Head-Doctors (also called Doctor Technical Advisor and Medical Director), an idea strongly opposed by the Chambers. They explicitly express their distrust of any Head-Doctor appointed by the hospital owner. Second, resolving the financial relation between doctors and hospitals.

In 1972, following a conflict between doctors and a local hospital, a member of the VVI, the VVI drafted a text on the statute of the Hospital-Doctor and proposed it for discussion to the commission. This text stated that all final decisions regarding policies of the medical organization are in hands of hospital management. But it considered that there also had to be room for a medical council, acting as an advisory organ. Management would be obliged to consult the medical council on specific items. But at the same time this advice was in no way binding for the management.

The specific items just noted were presented in the form of a list. It is interesting to notice that in a later text (1972) presented by the Confederation – which integrated large portions of the VVI-proposal – the participation of doctors in the hospital-management is greatly reduced. It is rewritten in order to make doctor participation an option, not an imperative.

In reaction to the Confederation-text the Syndical Chambers opted for a policy of confrontation. It called on all hospital doctors to gather in a General Assembly where a national action would be decided. In a final effort to save the Joint Commission its chairman, Dr Halter, sent a proposal-text to all participants. This text proposed, among others, creating a medical council representing all doctors and acting as a discussion-partner with management with the goal of a joint collaboration.

The same text also stipulated that management is obliged to consult the medical council on 17 specific issues. This listing had been set up during the workings of the Joint Commission and would not change much until its integration into the legislation

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of 1986. But the text was never debated by the joint commission because it was rejected by the Syndical Chambers. In their view it did not incorporate the – for them central – notion of '*gestion paritaire*' (joint-management).

1973–1986: Desaeger and Dehaene

On 26 January 1973, the Christian-democrat Jos De Saeger became Minister of Public Health (to 1977). During his tenure in office the central government initiated a stricter health policy. The Hospital Law of 1973 altered its predecessor of 1963 by introducing mandatory hospital planning, by compelling hospitals to establish an accountancy plan, and by compelling hospitals to send data on their financial situation and financial results to the Ministry of Public Health. In addition, it also demanded hospital planning on heavy medical equipment (for example medical scanners) and special services.

Minister De Saeger asked the Syndical Chambers to refrain from taking any national action such as a strike. Following the failure of the National Joint Commission Doctors–Hospitals, which ceased to exist, he transferred the setting of the negotiations to the National Hospital Council.

Switching the strategy pursued by his predecessors he intervened directly in the debates. He started informal negotiations with the Syndical Chambers, the sickness funds and the Hospital-federations. As a result of these negotiations, De Saeger presented a text that wished to find a solution for the organization of the hospital by the creation of a General Council, a Medical Council and the redaction of a statute for the Hospital-Doctor (1974).

On the medical council the text referred to the Halter-proposal. The text was innovative, it wanted by way of a General Council to incorporate the Sickness funds in the management of the hospital. The Minister asked all parties to make their commentaries. Most of these were rather negative, exception made of the Christian Sickness Fund and its hospital-federation.

But the national Government fell and all had to wait for the formation of a new Government and the reinstallation of Jos De Saeger to reengage the negotiations. The sickness funds became central in these, negotiating with both the Hospital-federations and the doctors' unions. It was in this context that the Syndical Chambers initiated an impressive u-turn. After having first criticized the De Saeger-text for being a way of bringing the sickness funds in the hospitals, it announced that it was starting negotiations with the sickness funds.

Result of these negotiations was an agreement (1974) between the Syndical Chambers and the Christian Sickness Funds proposing large concessions to the doctors in exchange for the uptake of the Sickness funds in the hospital's management. The agreement postulated the mandatory creation of medical councils, and restated most of the Halter-proposal. New is the introduction of the obligation for the management to obtain a conform advice (i.e. the principle of reinforced advice) from the medical council.

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Also, the profession enhanced its grip on the organization for the text clearly stated that the management could take no decisions on specific issues if it had not be backed by the General Council – in which both the doctors and the Sickness Funds were seating.

This text caused a wave of criticism from the other parties. The veto to this text was followed by new negotiations. This time the Hospital-federations took the lead and sought an agreement with the Syndical Chambers. Finally Minister De Saeger presented a Law-project at the National Hospital Council (1976). This text was a weakened version of his initial proposal. The role of the General Council was heavily reduced – a huge defeat for the sickness funds but an important victory for the hospital-federations. At the same time it meant an important step forward for the doctors, for the text had incorporated the principle of reinforced advice.

For most participants the new text was acceptable and could be used as a base for new discussions within the National Hospital Council. It was decided to create a workgroup (1976) to discuss the Law-project. But again all had to agree that the opinions were too different to reach any agreement (Prims 1997, 127).

In the 1980s the national government – from 1982 to 1988 a coalition of Christian-Democrats and Liberals – displayed a strong commitment to the reduction of public expenditure. On the level of governmental policy one witnessed an emergent neo-liberal ideology (Witte et al. 2005). The government focused on economical profitability and adopted a more interventionist stance (Vercauteren 2007).

With respect to the hospital-sector the government announced a moratorium on hospital beds, followed by their conversion to elderly care beds, and mergers among hospitals were imposed. Also in this period, the first steps were taken to reform hospital funding from a supply-led into a demand-led system.

Central figure in these reforms was the Christian-democrat Jean-Luc Dehaene, Minister of Social Affairs and Public Health. With respect to the topic of the medical council he also proved to be an important figure. After having announced his intention to tackle the problem he started private consultations with all parties in order to gauge the change of success of his endeavour. The result of these was introduced in the senate as Law-project number 653 (1984).

This text proposed the mandatory creation of a medical council in every hospital. This would assure the doctors' representation in the hospital, and be the channel by which they would integrate the hospital's decision-making process. Within the overall tasks assigned to the council the hospital-management has to consult the council on specific issues such as for example the rules on the organization and coordination of the medical services in the hospital, the creation of new services, changes to, split and suppression of services, the appointment, recruitment, and promotion of doctors.

In order to counter the text the VVI initiated discussions with the Minister, the senators of the Commission Public Health and the sickness funds. It fundamentally disagreed with the Law-project, in their eyes it provided doctors certain prerogatives that would breach the ultimate responsibility of the management. But despite this opposition the text of the Law-Project was approved by the senate.

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In reaction the VVI started a political lobbying on the members of the Chamber of Representatives, and was able to hold back the senate's text. The parliamentary work on this last was irremediably postponed due the fall of the national government. Within the newly installed Government Jean-Luc Dehaene again assumed the function of Minister of Social Affairs and Public Health. This time the resolution of the question of the medical council and statute would be solved by the issue of a Royal Decree, the famous Royal Decree number 407 (1986), by this bypassing the parliament.

Discussion

After the Second World War the legal bases were established for a compulsory HIS based on independent medical practice, free choice of health care provider (e.g. doctors, hospitals), fee-for-service payment of health care providers, and refunding of the patients by the sickness funds. The regulation of the overall system is based on negotiations between both health care providers (e.g. doctors and hospitals) and insurers (the sickness funds) (European Observatory on Health Care Systems 2000).

The Belgian system exists in reimbursements by means of private sickness funds, and in the supply of health care by private providers. We do not say that the state is of no importance in this story. Indeed, due to the collective organization of health care states have a central role to play (Moran 2000). Only the state possesses the legitimacy to make decisions binding for all. By means of national regulatory policies it can impose constraints or restrictions on the agency of groups or individuals. Interest groups will have to integrate the policy arena – the institutional setting in which policy making takes place (Blank and Burau 2004).

In Belgium, the private HIS-actors are integrated in the policy arena. Due to the involvement of such private interest groups or social movements, to hold out state-involvement, the role of the state is essentially defined in terms of financial support and the creation of a regulatory framework. With other words, the Belgian policy process accepts the pursuit of corporate interests by political means (Schepers 1993; see also Deferme 2007). An element present in our historical narratives.

As said, the expansion of the hospitals' medical market triggered tensions between the medical profession and the sickness funds and hospitals, but also between doctors. In order to eradicate all 'unfair and unethical' behaviour, the medical profession opted for a regulation of the internal medical market (the hospital) by the principle of joint-management. An instrument for this was the medical council.

From the start, doctors conceived it as a representative body aiming at the protection of their 'rights' within the hospital. With this instrument the medical unions such as the FMB or the Syndical Chambers sought to control the doctors' work conditions. This does not just imply the material (buildings) but also the legal and financial conditions under which doctors would practice medicine within the hospital.

In order to achieve such a regulation on an organizational level, the medical unions had to negotiate with the other HIS-actors. In the first period we see talks with

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the sickness funds (failed) and one specific hospital-federation (success). What is missing here is the existence of a national policy arena, which would only start after the 1964-strike.

In these negotiations the medical unions emphasized the doctors' central role in the hospital as key production workers. This position is determined by their professional knowledge and expertise. But, we would emphasize that this does not confer them automatically authority within the organization. Rather, authority originates from their legal monopoly on the practice of medicine, and the strong legal protection of their technical autonomy. Under pressure of the medical unions the legislator always shielded the doctors' technical independence. Using their professional knowledge and rights professionals aspired to acquire control on the organization.

The question for all was how far this could go. In the negotiations, three questions were debated. First of all, there was the question if the management should have the obligation to consult with the medical council? We witness in our data an early acknowledgement that doctors should have to be consulted on important matters pertaining to the hospital's medical activities.

Troubles started when the second (would the implications of this advice be binding for the management?) and third (what would happen if management and medical council disagree?) questions were discussed. We clearly see the syndical chambers and hospital-federations on a confrontation course on these topics. This illustrates the conflicts over *property*, by trying to create a control in favour of the professionals the professional group challenges the property of the hospital's owner. For the hospital-federations it was clear that the final full responsibility in the hospital belonged to management, and not the doctors, which had to be fully integrated in the hospital. The Syndical Chambers however, only wished to integrate hospital-management. They also saw themselves as the only legitimate source of medical practice regulation. These three questions illustrate the fact that one needs to place the relation between professional groups and the management of an organization within the relation between responsible and professional autonomy.

Next to the legally protected technical autonomy our data display a second power-axis used by the medical profession. Doctors concede a part of their honoraria back to the hospital in order to cover the hospital's costs, such as instruments, locals, etc. For the doctors it was clear that these honoraria were legally theirs, they considered that due to these financial transfers they could 'buy' a place for themselves in the hospital's management. For the Syndical Chambers the importance of the advice given by the medical council had to be related to the doctors' financial intake.

We better understand the relevance of this stance if we take into account the constant under-funding of hospitals. This implies that hospitals have to negotiate with their doctors, who have to concede a part of their fees to fill the hospital's deficit (Degadt and Van Herck 2003). For the hospital-federations it was, and still is, important to secure this financial resource. To this end the hospital-federations were ready to concede doctors certain rights. But they were soon to collide when it came down to formulating the terms of these rights.

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This brings us to conclude that doctors had two important sources of power. First, as key production workers with a legal monopoly and protection; and, second as bringers of financial capital. Doctors, thus, by way of a 'domination by virtue of a constellation of interests' - influence from the possession of goods or marketable skills – and a 'domination by way of authority' (Weber and Kalberg 2005) – influence by rules, in this case their legal rights – sought to establish a domination at organizational level.

To fully understand our case, one has to look at the agency and values of the dominant medical union. The Syndical Chambers are a militant and syndical organization, with a stance and methods more prone to confrontation. In their ideology the 1964-strike acquired an almost mythical proportion. It is portrayed as the time when doctors, threatened of being ripped of their liberty, fought back and defeated their enemies.

The Chambers' language is strongly infused with words such as threat, danger, war, aggression, conspiracy … all elements which portray the world in which doctors act as 'dangerous' – there are always evildoers (the state, sickness funds, hospital-federations, but also other medical unions) seeking to strip the doctor of his freedom and put him into 'servitude'.

At the core of the Chambers' values is the defence of the liberal medical ideology and the complete liberty of the practitioner. For the Chambers it is obvious that the doctor is the central figure of health care and that an enhancement of doctors' conditions could only be beneficial for patients. This also implies a rejection of extensive integration in the hospital. Only an integration in the overall decision-making process of the hospital could interest the Syndical Chambers (principle of joint-management).

Finally, we wish to discuss the relevance of the double closure concept. First, contrary to archetype-theory, it reasserts the necessity of a political perspective on organizations. By way of a (double) closure-perspective one acknowledges the struggle between groups to gain power or to influence its distribution within the organization. Ultimately, it allows one to recognize the role of this struggle on organizational structure and change. Eventually, thus, it proves helpful in that it connects a view on professional groups and organizations.

It helped us understanding the attitude of the medical unions. Work conditions in hospitals 'disrupted' outside work conditions. The double closure reminds us that the regulation of internal medical markets (such as hospitals) holds equal importance for the medical profession, both external and internal markets are in the end connected. Also, it facilitates the understanding of the profession's push 'towards management', which is equivalent to the push towards a control on the HIS-regulation.

However, we also feel that some caveats need to be formulated. In order to avoid a focus on demand-aspect, one needs to frame the (double) closure-perspective within the continuum professional autonomy – responsible autonomy. More fundamentally, we feel that a conceptual focus on informal control hampers its full development. One should abandon the conceptual distinction between formal and informal structure,

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and replace it by an acknowledgement of different views on regulation within the organization (Reynaud 1988). This would better fuse the questions of double closure and regulation

Also, we need to give equal value to both self-interestedness and altruism in evaluating professional discourse. We can imagine doctors truly believing that enhancing their self-interest serves their patients' interests. With other words, views on regulation are linked to the actors' values. In this context we should be aware of Buchner-Jeziorska and Evetts' question (1997), and look at groups seeking to head this system of regulation, by which they can impose their view on regulation.

Conclusion

We addressed the attitude of doctors towards management in a HIS-context. This last allows private actors (sickness funds, hospitals, doctors …) to remain independent of the state, even to influence the national policy process. In order to maintain a grip on their working conditions and preserve doctors' independence the profession sought to be integrated in the regulatory activity. The Hospital-Law of 1986, which, by way of the medical council, gives doctors a legal role in the decision-making process is to be understood as resulting from the agency of medical unions, but also from a policy process which integrated all interest groups. Hospital organizational structure in the end is thus shaped by the HIS-actors' agencies.

We argued elsewhere (2009) that Belgian hospitals can be described as a professional bureaucracy. Within functionalist thought one makes this structure function of the qualities of work undertaken in the organization. In order to maintain organizational performance it assumes that organizations dealing with professional work come to create a specific structure such as the professional bureaucracy (especially see Litwak 1961). However, our data suggest that the legally defined hospital-structure resulted from the agency of medical unions, and a policy process that integrates interest groups.

It has been argued that while sociologists underscored the importance of power in organizations, business schools emphasized efficiency (Hinings and Greenwood 2002). However, as became clear, both are not detached (see also Clegg et al. 2006). Efficiency discourses are prescriptions of how work is to be done 'best', and thus pertains to the regulation and control of agency. This links it to power and authority. Particularly if we acknowledge that different groups hold different views on how work should be regulated, the notion of 'best way to do a job' becomes object of struggles between those groups.

Finally, our article suggests that certainty, as an alternative for uncertainty (Crozier and Friedberg 1981), can increase power. By the creation of rules, on how one should act, enhanced certainty in the intra-organizational relations was desired. In short, one sees professional agency directed at the creation of a structure influencing the agency of professionals and management.

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