

HOSPITAL GOVERNANCE IN
LEBANON:
CORPORATE AND CLINICAL
GOVERNANCE IN NON-PROFIT
PRIVATE HOSPITALS

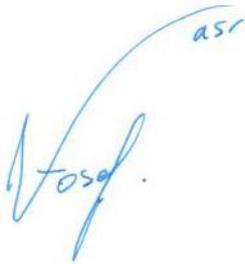
JOSEPH NASR

A thesis submitted in partial fulfillment
of the requirements of the
University of Brighton
for the degree of
Doctor of Philosophy

September 2017

Declaration

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.



20 September, 2017

Table of contents

Abstract	5
Chapter 1 Introduction	7
Chapter 2 Literature Review	15
Chapter 3 Methodology and Methods	65
Chapter 4 Quantitative data analysis	111
Chapter 5 Qualitative data analysis	151
Chapter 6 Discussion	181
Chapter 7 Conclusion	227
References	235
Figures and Tables	259
Appendix	263

Abstract

There are multiple internal and external governance mechanisms intended to ensure the functioning of corporations, while maintaining the interests of stakeholders. Although corporate governance is a growing area of research, empirical research is restricted. This research study critically examines historical definitions of corporate governance. It explains the relationship of corporate and clinical governance and explores clinical governance as a subset of hospital governance. It aids an understanding of hospital governance through an examination of the governance of a sample of non-profit Lebanese hospitals. It examines the relationship of governance with performance. It explores how managers and clinicians are incentivized and the relationship of this to performance. It compares the governance processes between three hospitals and examines the influence of external factors.

Mixed methods are used, including quantitative surveys that are developed and explored using factor analysis, and qualitative semi-structured interviews. The findings are used to critically examine major corporate governance theories and their relevance to understanding hospital governance, by understanding the perspectives of those employed in the hospitals.

Using critical realism as a theoretical framework, the findings show how the mechanisms of hospital governance are perceived. The survey data from 207 participants were subjected to principal components analysis which resulted in a single factor solution representing individual perceptions of hospital governance for all respondents. The results of perceptions differed according to differences in managerial role, management experience, management education, leadership role, number of years working at the hospital, current role, and the hospital studied. Differences in age and gender had no significant effect. Findings also revealed that clear methods of performance measurement were perceived to be in used in each of the three hospitals, with a good knowledge of the used performance measurement. Hospitals have a good mission, and clear structures. There is a good knowledge of the external stakeholders to the hospitals and their roles, and

the involvement of external stakeholders in hospitals is proven to be core to their overall ability to function. The hospitals have good clinical performance and governance systems in terms of quality and safety. On the other hand, there are management deficits. There is an absence of monetary incentives which was mainly caused by corporate governance events represented by a conflict of interest case. This appeared to be caused by the minor role of the board of directors, accompanied with the lack of adequate background, knowledge, and education of its members, resulting in a lack of control over the CEO. These corporate governance events were shown to change interviewees' perception of hospital governance. The hospitals also had problems with the internal reporting systems.

The contribution of this study lies in illuminating the employees' perspectives of corporate governance in the hospital settings. It questions and informs theoretical approaches to the traditional principal-agent and stakeholder models. It creates tools for measuring clinicians' and managers' perceptions of hospital governance where they work. It shows how corporate governance 'events' affect both clinical and corporate governance. It provides evidence of the importance of the stakeholder approach to hospital governance and demonstrates the influence of external factors on internal hospital governance.

Chapter 1

INTRODUCTION

With the rapid improvement of medicine that has subsequently led to an increase in the average age of a person, population size around the world is exponentially increasing. With this expansion in population size, improving the performance of healthcare has become a necessity if healthcare institutions are to meet the needs of this larger population size. Whilst this is a challenge relevant to healthcare institutions across the globe, different countries face different challenges. Some of these challenges are contextual and others are relevant to the ways by which individual institutions are governed. This research study will be targeting Lebanon as a focused example to explore how research on corporate governance can be used to help contribute to knowledge of governance in the hospital context. The compulsion to develop high-performing and sustainable hospital governance may not be as strong in some countries as it is in others. As stated by Jamali et al. (2010: 594),

“In countries such as Lebanon, where most of the organisations are for-profit or non-profit with limited community representation, and where the legal system is under-developed with respect to malpractice, pressures for sound governance might be less accentuated”.

Therefore, this research aims to make a contribution to the evidence supporting the development of hospital governance through a detailed examination of a sample of Lebanese non-profit hospitals. The research will examine the internal and external factors influencing hospital governance. This evidence will contribute to an understanding of what constitutes ‘good’ hospital governance in such settings. This includes examining the perception of hospital governance demonstrated by staff.

The chosen sample of hospitals was three non-profit private hospitals within the Mount Lebanon region which is one of the biggest regions of Lebanon. It is also the largest province in terms of population size, and has the largest number of hospitals. Moreover, it has the largest percentage of non-profit

private hospitals, making a total of 47% of all the Lebanese non-profit private hospitals.

The term “corporate governance” became commonly used in modern business 40 years ago. It has since then been used frequently by academics and professionals who have developed new viewpoints and definitions of this term. Adrian (2000) defined corporate governance in a simple way, stating that “management is about running the business; governance is about seeing it run properly”. The term ‘governance’ is used in different conceptual frameworks and neologisms. Examples are corporate governance, clinical governance, cultural governance, hospital governance, social governance, global governance, E-governance, and government governance. The common term that is shared is ‘governance’ which refers to the

“means for achieving direction, control, and coordination of wholly or partially autonomous individuals or organisational units on behalf of interests to which they jointly contribute” (Lynn et al., 2001: 6).

One of the most common definitions for corporate governance is that of Sir Adrian Cadbury (2000:8) who defines it as “the system by which companies are directed and controlled”. One common theme for all the different applications of corporate governance is ‘agency theory’ where the principal attempts to persuade the agent to work for his benefit rather than following the agent’s self-interests. Similar to corporate governance, clinical governance can explain the agency problem as part of agency theory. Clinical governance is about ensuring that clinicians and healthcare professionals, as ‘agents’ within the healthcare system, are accountable for quality and clinical performance (Mannion and Davies, 2002).

Governance looks for a solution to the agency problem. This solution lies in what is called the ‘checks and balances’ which refer to “all kinds of relationships, functions, and procedures that are built into the system, exactly to prevent someone from doing the wrong thing” (Eeckloo et al., 2007: 79). The board of directors plays an important role in these checks and balances, but the existence of the board does not guarantee a good outcome. Non-profit hospitals which constitute this study’s selected sample, and which constitute the majority of European hospitals, have no real shareholders.

Therefore, the emphasis here shifts towards those stakeholders whom are to be protected by the checks and balances.

Hospitals are more complex than most other organisations. Nowadays, hospital management systems are experiencing modifications that are caused by many factors including financial pressures, changing technology and clinical knowledge, demographic changes and related shifts in disease outbreaks, increase in public expectations, changes in human resources structures and personnel knowledge, and the internalization of the health care systems. With all these factors, new entities have been added and old systems have been modified. In governance terms, a shift in the checks and balances was required to determine how the decision-making processes in the hospitals will be directed and evaluated. Clinical governance, for instance, has been given a major role in addressing problems of quality and safety which most hospitals are facing worldwide.

Changes are also taking place between the world of trustees and the world of management. In the modern corporate governance systems, there is a tendency in many countries, such as in the case of Lebanon, by which the traditional organizers of hospitals, such as religious congregations (as in the case of this study) and local communities, are willing to take a step back from their direct involvement in the day to day running of the hospitals (White, 2000), thus leaving their tasks, at least in part, to the management staff of the hospitals. This is because of the growing complexity in the management system that prevents the trustees from being able to fulfil both managerial and directoral functions appropriately at the same time.

Corporate governance research has tended to focus on a narrow category of for-profit organisations. Extending corporate governance theories to include not-for-profit organisations was problematic due to its central focus on return on shareholder investment. In a study of 82 hospitals in Belgium, Eeckloo et al. (2004: 4) stated that “there simply is no such thing as ‘the’ corporate governance model”. They broaden the definition of corporate governance referring to Freeman (1984) and the OECD (1999) by describing it as “the system by which companies are directed and controlled” (Cadbury, 2000; Freeman, 1984 and OECD, 1999 in Eeckloo et al, 2004: 3). They describe how corporate governance usually has a qualitative essence and therefore it

can become a general description for all types of rules and guidelines needed for the optimization of the firms' governance structures. They also broaden the question of 'to whom' the study of corporate governance is relevant by saying it is concerned with preserving the interests of any person who is affected by a firm's achievements – effectively the firm's stakeholders (Freeman, 1984 and OECD, 1999 in Eekloo et al., 2004).

In contrast to corporate governance, hospital governance is described by Eekloo et al. (2004) as having a more institutional approach. They defined it as being the process of navigation through the functioning and effective performance of hospitals. Its main function is to define the hospital's mission, set its objectives, and support and monitor their implementation. They described it as concerned with the "structuring and functioning of the governing bodies of hospitals" (Eekloo et al. 2004: 2). Its function is to provide an integrated approach to supporting and supervising all hospital activities, including clinical performance.

In healthcare contexts, it is recognised that there is close interaction between corporate governance and clinical governance. Corporate governance has a wider scope focusing on corporations in general (Jamali et al., 2010), while clinical governance is more involved in "planning and organizing governance structures for safety and quality; and sponsoring a patient focus" (Braithwaite and Travaglia, 2008 in Jamali et al., 2010: 593).

As stated by Dalton et al. (2003), agency theory dominates corporate governance research. Early corporate governance research primarily focused on internal governance, such as the relationship between a company's managers and shareholders, in order to address and understand the agency problem. Theories such as internalization theory and agency theory were developed for this purpose (Fliaotchev and Wright, 2011). Moreover, agency theory recognizes that there can be inherent issues in: the role and nature of ownership; the composition of the board of directors; the separation of the managers and owners/ shareholders; executive remuneration; and the role of the market in governance.

Corporate governance scholars have recently criticized the historical focus of corporate governance research on agency theory alone. Some scholars

suggested looking for a wider range of theoretical perspectives for the study of corporate governance, seeking perspectives that both theoretically complement and substitute agency theory (Daily et al., 2003). Daily et al. (2003) suggested a “multi theoretic approach” to corporate governance for perceiving the mechanisms and structures that might improve organisational functioning. In terms of open system approaches, Mayer (2013) for instance, argued that this basic definition of corporate governance should be broadened to incorporate a wider view of whose interests are at stake when we consider the success or failure of corporate institutions. Inter-relationships between stakeholders and other external factors were Mayer’s major concern regarding their effect on the internal governance of corporations.

Taking into account recent criticism of corporate governance research that looks only at the internal governance structures of the firm through the lens of agency theory, this research argues that there is still value in agency theory based approaches. However, whilst this research will focus on the internal relationships relevant to agency theory it will also give theoretical attention to the external factors relevant to hospital governance in Lebanon. This study began by exploring the literature on corporate governance; specifically the literature that refers to agency theory as an approach to understanding hospital governance, stating the different views and definitions of the term ‘corporate governance’ according to leading researchers in this field. The nature of the ‘agency problem’ which is considered to be at the core of corporate governance concerns was explored and responded to by hospital managers, and its effect on hospital performance was measured. This was done through a comparison of governance structures, approaches to performance and performance measures, and the use of governance mechanisms including incentivisation. It considered the theoretical development of this field of research in terms of its treatment of internal and external governance conditions. It specified external stakeholders and external factors relevant to internal hospital governance and checked the extent to which they influence internal hospital governance.

Social sciences deal with the human world which is fundamentally different from the natural sciences dealing with the physical world. Hence, when studying each of these worlds, strategies should be adapted to get relevant results. In this research study, critical realism has been chosen as an approach to study hospital governance in the selected target hospitals. Critical realism is a philosophical approach that combines the general philosophy of science with the philosophy of social science, to illustrate a crossing point between the natural and social worlds. It is one of several theoretical methods that have emerged for mixed methods research, and is frequently used in social sciences for mixed methods. It takes place as a midpoint between positivism and interpretivism (Mingers, 2004; Venkatesh et al., 2013). It aids in better understanding the subject of study through supporting the idea of complex social reality (Archer et al., 2013; Bhaskar, 1978). Taking into consideration that participants in this study may think about hospital corporate governance differently according to their positions and their situations in the corporation, critical realism was the best choice for this study, as it can validate both the quantitative and qualitative results based on 'actual events'. These actual events were checked for their correlations to 'real causes' through the triangulation of qualitative and quantitative data with the use of sequential data collection as mixed methods triangulation can be perceived as the aspect of retrodution adopted by critical realism. Triangulation is

“an epistemological claim concerning what more can be known about a phenomenon when the findings from the data generated by two or more methods are brought together” (Moran-Ellis et al., 2006: 47).

Retrodution joins both the quantitative and qualitative result interpretations into realistic analysis and produces a critical realist account of actual events and real causes (Downward and Mearman, 2007).

The research started with a literature review, covering the most important published literature that is directly and indirectly related to corporate governance in Lebanese hospitals. Based on the gaps in the literature, the survey instruments were prepared and interview schedules were drafted to

reflect the core research theories and concepts of interest, and to answer the research questions.

Field work took place in three non-profit private hospitals within the Mount Lebanon region, as it represents the health sector of the largest Lebanese population and the largest amount of hospitals, especially non-profit private hospitals. The sampling approach was convenience sampling, with hospitals chosen based on their convenience in terms of different aspect like location, safety, size, type (non-profit private hospitals), and others.

The fieldwork for the research began by selecting different hospitals, then access was negotiated, ensuring ethical and research governance requirements were satisfied at the local and institutional level. There were two stages to the research design. The first stage involved the development and distribution of a survey to understand how hospital staff perceive hospital governance. This was done by testing the extent to which respondents agree or not with the chosen statements containing key hospital governance concepts. The survey was designed in a way to cover all research questions of this research, which incorporate the major concepts of corporate governance as addressed in the literature review, specifically hospital governance. It was first collected through online survey collection, followed by paper-based collection.

Quantitative data collection targeted board members (known as members of the general council who act as owners or shareholders), senior managers, and clinicians. The survey was distributed to a total population of 582 participants. A total of 207 completed surveys were collected, making a 35.6% response rate. Analysis of the quantitative data collected through the surveys was then conducted.

The second stage was built upon the first by using its findings to further develop the interview schedule which acted as a systematic approach to gain deeper insight into the hospital governance issues identified in the findings of the quantitative analysis. Eight managers from the three hospitals were interviewed using semi-structured interview schedules. Interviews covered hospital governance topics through both clinical and corporate governance. The interviews were also used to report a number of managers' points of view with respect to hospital performance and the incentivisation of

managers. The data provided an understanding into how and why managers feel accountable to stakeholders including the owners/shareholders of the hospitals. It also provided an interpretation of their views and working experiences and how they thought improvements can be made. Qualitative data collected by the interviews was transcribed and analysed using thematic analysis according to the theoretical framework specified at the beginning of the study. Thematic analysis was performed through engaging with a number of different steps: transcription, followed by coding, then by analysis, and finally by writing the report/ analysis (Braun and Clarke (2006)). These steps are explained in detail in the methodology and methods chapter.

Accordingly, the structure of this PhD thesis is as follows: it begins with an introduction chapter, then a literature review chapter, followed by a methodology and methods chapter, then a quantitative data presentation and analysis chapter, then a qualitative data analysis chapter. Further, a discussion chapter follows. Finally, a conclusion chapter summarizes and concludes the whole thesis.

Chapter 2

LITERATURE REVIEW

2.1 Corporate Governance

In her 25 year review of Corporate Governance research, Denis (2001) states that the fundamental origin from which the need for corporate governance emerges relates to the problems associated with the separation of ownership and control that we see in the modern corporate form of organisation. She proceeds to quote Adam Smith's *Wealth of Nations* in which the fundamental problem is described as follows:

“Being the managers of other people's money (rather than their own) ... it cannot be expected that they should watch over it with the same anxious vigilance” (Adam Smith cited in Denis 2001:2)

The concept above is referred to by corporate governance scholars as ‘the agency problem’ and though opinions differ on who the key stakeholders are and why conflicts of interest arise, it is the central concern of all corporate governance research. An agency problem emerges from agency theory. Agency theory is concerned with the relationship between two parties: the principal and the agent. According to Zeckhauser and Pratt (1985), an agency relationship arises whenever one individual depends on the action of another. Here, the individual taking the action is the *agent*, and the affected party is called the *principal*. Whenever a principal delegates control or decision-making authority to an agent, an agency relation arises. Starting at the top-level hierarchy of a corporation, shareholders are the principals who appoint top managers (the agents) to use the corporation's resources most effectively (Jones, 2010). Hence, the relationship occurs between a principal and an agent whenever the principle hires an agent to perform services on behalf of the principal, and represent him in connections with a third party. Agency theory deals with resolving the problems that may exist between these two parties. An agency problem arises whenever one of two problems that the theory addresses occurs: the first problem occurs when a conflict (sometimes a conflict of interest) occurs between the agent and the principal, accompanied by a difficulty or high expense for the principal. The second

problem arises when the agent and the principal have different approaches to risk; one is risk averse and the other a risk taker, and each is willing to act differently towards this risk (Investopedia, 2013; Jones, 2010).

Within the field of management studies, the agency problem is described as arising within a firm whenever managers (agents) have incentives to pursue their own interests at the shareholders' (principals) expense (Agrawal and Knoeber, 1996).

Agents that are considered to be the managers should exercise their power to move their companies forward, while preserving their responsibilities towards shareholders and stakeholders of the company (Mallin, 2005 in Jamali et al., 2008). There will frequently be unavoidable potential conflicts of interest between shareholders and senior managers running the business. These conflicts should be dealt with through balancing the power of the management executives by increasing their accountability to the shareholders (Cadbury, 2000). Claessens and Yurtoglu (2012) identify one cause as being the multiple steps that separate shareholders from the final user of their capital. Claessens (2013) argues that corporate governance mechanisms and specific ownership structures are needed to address these issues (Claessens, 2013). In an optimal situation, corporate governance researchers argue that 'good' corporate governance is expected to lighten the agency problem and diminish managers' motivation to prioritise their own interests at the expense of shareholders (Shleifer and Vishny, 1997 cited in Chen *et al.* 2012).

Corporate governance is a concept that has no specific unified definition, and hence there is a diversity of different interpretations that provide the clearest definition of the concept. A broad definition for corporate governance would be a set of mechanisms through which firms operate when ownership is separated from management (Cadbury Committee, 1992). Shleifer and Vishny (1997) define corporate governance as the ways in which suppliers of finance to corporations assure themselves of getting a return on their investment. Parallel to that, Gillan and Starks (1998) define it as a system of laws, rules, and factors that control the functioning of a company. From an economics point of view, Mathiesen (2002) defined it as a field in economics that investigates how to secure or motivate efficient management of

corporations by the use of incentive mechanisms, such as contracts, organisational designs and legislation. Hambrick et al. (2008: 381) saw

“corporate governance as referring to the formal structures, informal structures, and processes that exist in oversight roles and responsibilities in the corporate context”.

For Garvey and Swan (1992), corporate governance is a determinant of how the top decision makers of a firm, control and monitor contractual relationships. In other similar views, John and Senbet (1998: 372) describe it by saying that it “deals with mechanisms by which stakeholders of a corporation exercise control over corporate insiders and management such that their interests are protected”. This definition is close to that of Hambrick et al. (2008: 384) who defines corporate governance as referring to “the structures and processes by which an organisation’s assets and activities are overseen”. In the title of his article, Wolfensohn (1999) stated that corporate governance is about promoting corporate fairness, transparency and accountability. Cadbury (2000: 8) defines corporate governance simply as “the system by which companies are directed and controlled”. The importance of corporate governance according to Page (2005) lies in its mission of continuously redefining the rules, laws, and regulations that direct the companies’ operations, while guaranteeing the rights and interests of shareholders, stakeholders and managers; thus maintaining a stable and transparent environment (Page, 2005 cited in Jamali et al, 2008).

In general, researchers view corporate governance mechanisms as being divided into two groups: internal and external to the firm. Figure 2.1 simplifies those two groups.

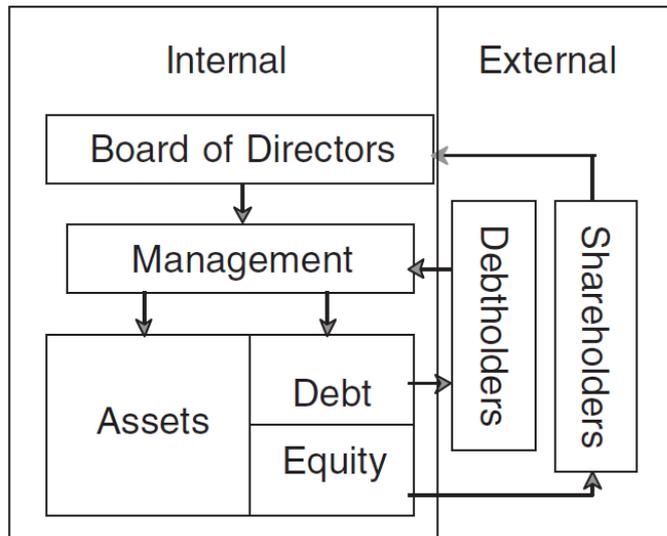


Figure 2.1 Corporate governance and the balance sheet model of the firm

Reproduced from PowerPoint slides accompanying Ross et al., 2005 cited in Gillan, 2006: 382

The perceived line of separation between the external group and the internal group is understood as the main source of the agency problem. This creates a demand for corporate governance structures and mechanisms. Gillan (2006) describes this separation between the capital providers and the management as creating a demand for corporate governance structures. Similarly, the internal mechanism for corporate control according to Hirshleifer and Thakor (1994) is represented by the actions of the board of directors while the external mechanisms are represented by the actions of an acquirer providing the capital. Kozarzewski (2006) described the corporate governance structure as specifying the distribution of rights and responsibilities among different participants in the corporation, such as the board, managers, shareholders and other stakeholders, and as laying down the rules and procedures for decision making.

Aware of the many similarities and differences between the definitions of corporate governance in the literature, the research will adopt the definition of the Cadbury Committee in 1992. They defined corporate governance as “the system by which companies are directed and controlled” (Cadbury, 1992: 14). This definition will constitute the basic definition of corporate

governance in this research. The research selects the Cadbury Committee's definition as this definition is similar to how I view corporate governance. This is an excellent concise definition that corporate governance is a method or system of government or management of a corporation. A corporation is defined in the Oxford Online Dictionary as 'a large company or group of companies authorized to act as a single entity and recognized as such in law'.

From a financial point of view, Claessens et al. (2013) described the channels through which corporate governance matter, to be the increased access to external financing by firms, lowering the cost of capital, better operational performance, less financial crises, and better relationship with all stakeholders. In their article on the synergies and interrelationships between corporate governance and corporate social responsibility, Jamali et al.(2008) referred to several authors in stating that corporate governance generally revolves around a set of universal characteristics, which include ensuring accountability to shareholders and stakeholders (Keasy and Wright, 1997), setting up mechanisms for controlling managerial behaviour (Tricker, 1994), running the companies according to the requirements of international and national laws and making them answerable to all stakeholders (Dunlop, 1998), ensuring that reporting systems facilitate good governance (Kendall, 1999), and incorporating stakeholder and shareholder values through coming up with effective leadership/strategic management processes (Tricker, 1994; Kendall, 1999). Jamali et al. (2008) also referred to Huse (2005) and Van den Berghe and Louche (2005) to state that leadership, direction, control, transparency, and accountability attributes lie at the heart of sound and effective corporate governance (Huse, 2005; Van den Berghe and Louche, 2005 cited in Jamali et al., 2008).

Variations of these attributes of corporate governance appear in the OECD (Organisation for Economic Co-operation and Development) principles of 1999. The OECD came into force on 30th September 1961. It had originally twenty member countries, which were Austria, Belgium, Canada, Denmark, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The following countries became

members subsequently through accession: Japan, Finland, Australia, New Zealand, Mexico, the Czech Republic, Hungary, Poland, Korea, and the Slovak Republic; hence becoming thirty member countries (OECD Principles of CG, 2004).

The mission of the OECD is to promote policies that will improve the economic and social well-being of people around the world. It provides a forum in which governments can share experiences and seek solutions to common problems. It works with governments to understand what drives economic, social and environmental change. It also measures productivity and global flows of trade and investment. It analyses and compares data to predict future trends. Furthermore, it sets international standards on a wide range of economic behaviours, from agriculture and tax to the safety of chemicals (OECD Principles of CG, 2004, and official website of OECD www.oecd.org).

The OECD principles of Corporate Governance are actively used in both OECD and non-OECD countries after being issued in 1999, as they have gained worldwide recognition as an international benchmark for sound corporate governance (Jesover and Kirkpatrick, 2005). Being aware of the different factors that affect the governance of firms in general, and their importance to the long-term success of these firms, the principles of corporate governance focus on governance problems that result from the separation of ownership and control. These principles act as guides for policymakers in improving the legal, institutional and regulatory framework supporting corporate governance (OECD Principles of CG, 2004). Cadbury (2000) stated that the principles by themselves are not a code, but he described them as a primer for those willing to write up codes. According to the article stating the corporate governance principles of the Organisation for Economic Co-operation and Development, these principles are highly relevant to non-OECD economies (OECD Principles of Corporate Governance, 2004). While the relationship between management and shareholders is the central element of corporate governance, the OECD principles take into consideration that governance issues also arise from a difference in control between certain shareholders and other minority shareholders.

The OECD states that

“corporate governance involves a set of relationships between a company’s management, its board, its shareholders and other stakeholders. Corporate governance also provides the structure through which the objectives of the company are set, and the means of attaining those objectives and monitoring performance are determined. Good corporate governance should provide proper incentives for the board and management to pursue objectives that are in the interests of the company and its shareholders and should facilitate effective monitoring” (OECD Principles of Corporate Governance, 2004: 11)

The OECD principles cover six key areas of corporate governance. Below is a description of few of them:

a. Ensuring the basis for an effective corporate governance framework

The corporate governance framework should promote transparent and efficient markets, be consistent with the rule of law, and clearly articulate the division of responsibilities among different supervisory, regulatory, and enforcement authorities.

b. The rights of shareholders and key ownership functions

The corporate governance framework should protect and facilitate the exercise of shareholders’ rights.

c. The equitable treatment of shareholders

The corporate governance framework should ensure the equitable treatment of all shareholders, including minority and foreign shareholders. All shareholders should have the opportunity to obtain effective redress for violation of their rights.

d. Disclosure and transparency

The corporate governance framework should ensure that timely and accurate disclosure is made on all material matters regarding the corporation, including the financial situation, performance, ownership, and governance of the company (OECD, Principles of CG, 2004).

Since the above principles were agreed upon in 1999, they have formed the infrastructure for corporate governance in both OECD and non-OECD countries. They are planned to assist those countries in improving the frameworks of corporate governance and offer suggestions for all parties interested in developing good corporate governance. The principles are considered by the OECD to be evolutionary, and it is recommended that they should be reviewed frequently with important variations in circumstances. Their purpose is to serve as a reference point, and they are described to be 'non-binding' principles. It is up to governments and firms to choose how to apply these principles in developing their corporate governance structure. The principles are described by the OECD as 'living instruments' which offer standards for good corporate governance practice as well as guidance for their successful implementation. Their description as 'living' reflects their adaptability for different circumstances in different regions and countries (OECD Principles of CG, 2004). Moreover, these principles were subject to review in 2002 by the OECD steering group on corporate governance. The review was based on surveys examining the corporate governance challenges that the OECD members have mainly faced since the principles were adopted in 1999. The revised principles also built upon the experiences from non-OECD countries (OECD Principles of CG, 2004).

In Cadbury's (2000:7) view, "there is no single right corporate governance model and that the best approach is to start from whatever system is in place and to seek ways of improving it". In an identical expression stated in the article of the OECD principles, the Business Sector Advisory Group on Corporate Governance stressed on avoiding the 'one size fits all' approach in corporate governance; suggesting that countries and corporations should build their corporate governance forms according to their existing structures and systems. They stated that there is no single model of good corporate governance, and that the OECD principles have set common elements that make good corporate governance. Therefore, in order to remain competitive, corporations must adapt and be innovative in their corporate governance practices (OECD Principles of CG, 2004 and Cadbury, 1999). Clearly, it has been a convention of corporate governance research to study the relationships between corporations and their respective shareholders,

creditors, financial markets, institutions, and employees. Collectively, these groups are described as having one major objective, which is to maximize the contribution of firms to the overall economy (Claessens, 2006). However, recently, corporate governance scholars have argued that this definition should be extended to incorporate a broader view of whose interests are at stake when we consider the success or failure of corporate institutions (Mayer, 2013). Stakeholders include the contractual stakeholders such as the shareholders, managers, and other employees, suppliers, customers, consumers, bankers, but also other stakeholders outside the company whose interests could be affected by corporate behaviour including the local, national, and international societal interests (Freeman, 2010). In an interview discussing his book *Firm Commitment*, Colin Mayer, the Peter Moores Professor of Management Studies at the Saïd Business School at the University of Oxford, portrays the corporation as being 'hijacked' by one particular group called the shareholders. He believes that "the profits and shareholder returns should be a product of the success of a corporation, not the purpose" (Mayer, cited in Bell, 2013: 36). He also defines the role of the directors of corporations to have commitments to only that particular group. Mayer describes a trusted firm as having three major qualifications: only shareholders with long-term commitments should have control in the corporation; the corporation must clearly clarify its purposes and values; and responsibility should be in the hands of an independent board of directors having a duty to ensure that the corporation is abiding by its values and purposes (Bell, 2013).

Therefore, the field of corporate governance research now includes the study of 'corporate social responsibility' (Claessens, 2003). Corporate governance and corporate social responsibility are closely related fields since, as Jamali et al. (2008) describe, they both strive to articulate a corporate institution's commitment to its stakeholders and the nature of its interaction with the community in general. Gill (2008) states that corporate social responsibility has become an important means of integrating social and environmental concerns. He adds that even though the models derived from this are sometimes achieved at the expense of financial outcomes, it provides benefits to employees, society, and customers, to understandings of

corporate governance. Tuan (2012) directly linked corporate governance to corporate social responsibility in his study on the Ho Chi Minh City Stock Exchange in Vietnam, proving that in this case attentiveness to corporate social responsibility positively influenced corporate governance.

Good corporate governance practices will be reflected by various benefits that increase the efficiency and appropriate performance of a corporation via more efficient management, better asset allocation, better labour policies, improved efficiency of investment decisions, improved cash flows, reduced agency risks, increased firm share prices leading to lower cost of capital, improved rates of return on equity, higher valuation, higher profits and sales growth, and lower capital expenditures, thus all leading to higher dividends to shareholders (Claessens and Yortoglu, 2013). It also strengthens the rules of law and democratic governance in building strong companies through improving relationships among investors, boards of directors, managers, and other stakeholders. It strengthens business strategies, clarifies accountability, enhances shareholder protection, and attracts quality employees. Moreover, it creates a demand for better public governance and helps prevent economic failures. It improves access to outside capital and builds and improves the company's reputation and trust (Gompers et al., 2001; Klapper and Love, 2004; La Porta et al., 2002; and Shleifer and Vishny, 1997). The OECD viewed that having good corporate governance practices will enhance confidence of investors, thus inducing new sources of financing (OECD Principles of CG, 2004).

Corporate governance is an ongoing process (Epetimehin, 2013: 332). Sound corporate governance can be reflected by five main elements: good board practices, appropriate control of environment and processes, strong regime of disclosure and transparency, protection of shareholder's rights- especially minority shareholders, and strong commitment to corporate governance reforms (Bushman et al., 2004; La Porta et al., 2000; Aguilera and Cuervo-Cazurra, 2004). Although the good corporate governance has lots of benefits, those benefits are at real costs. For example, dedicated and experienced staff must be hired like governance specialists, external counsels, auditors and consultants.

2.2 History of Corporate Governance

According to the book *Corporate Governance* by Kostyuk and Braendle (2007), the origin of the term corporate governance is derived from a correlation between the governance of nations and the governance of corporations. From Cheffins's (2012) point of view, there is no isolated historical treatment for corporate governance, and due to the gigantic subject, he sees that there may never be a definitive one. In his article *Corporate Governance: History without Historians* which outlines the historical evolution of corporate governance in the United States, Britain, Germany, France, and Japan, Gary Herrigel (2006) states that the corporate governance arrangements were historically understood as the procedures determining the relationship between the owners and the management of corporations. He also describes that the origin of the corporate governance systems comes from different distinct disciplines including economics, legal studies, sociology, political science, and business history.

After the turn of the 20th Century, in the early 1900s, new business structures were created, separating the owners from the management functions, exponentially removing the control out of the hands of business owners (Cheffins, 2001 cited in Grant, 2003). There was a concern about the growing number of small powerless shareholders. Those small shareholders were not able to influence the functioning of the corporations' management. The main consequence of such powerlessness was that the shareholders no longer controlled their corporations. Since managers were delegated the control, the interest of shareholders was no longer obeyed, and hence there appeared a conflict between the interests of shareholders and those of managers (Wells, 2010). During this period, privately owned companies used the opportunity to raise their capital through the public sales of stocks. The owners' role changed from active participants to passive observers as ownership was dispersed and control diminished (Grant, 2003). Berle and Means (1932) provided a view to this shift of control that ownership was transformed into a possession of a symbolic piece of paper while responsibilities and power were in the hands of the management. Before the appearance of the term 'corporate governance', a similar concept named as 'agency theory' was widely used with the emergence of the separation of

ownership and control in the early 1900s (Grant, 2003). In these theories, management or similar employed professionals are the 'agents'. Agency theory analyses the conflicts occurring due to the agency relationship, described by Jensen and Meckling (1976) as

“a contract under which one or more persons (the principal (s)) engage another person (the agent) to perform some service on their behalf which involves delegating some decision-making authority to the agent” (Jensen and Meckling, 1976: 308 cited in Grant, 2003).

In 1909, the United States Congress passed a series of legal acts dealing with corporate income tax. Then in 1916 the sixteenth modification of legal acts made the taxation of the corporate profits a law (Washburn, 1966 in Grant, 2003). In 1919, the Michigan courts set a legal precedent while analyzing the case of *Dodge v. Ford Motor Company* for responsibilities of management and corporate governance; stating that the profit of shareholders is the major goal of organizing a business corporation, and that the power of directors should be employed for that purpose (Morrissey, 1989, Himmelstein & 1916 cited in Chang, 2003). Managers were responsible for coordinating the functioning of the business in order to fulfill this goal (Washburn, 1996 cited in Grant, 2003).

In the 1920s the separation of ownership and control was a topic under the spotlight. There was a real considerable 'explosion' in the growth of world stock ownership in the 1920s, when a huge amount of Americans became first-time investors (Ott, 2008 cited in Wells, 2010). An economic boom occurred in the United States in the 1920s, ending up with a stock market crash in 1929, along with a decade of depressed economic situation (Kristie, 1997 cited in Grant, 2003). In part the crash was caused by investors borrowing money to buy stock investments. Allegations were made that senior employees overstated the value and potential benefits of investing in their corporations. The separation of ownership and control became a key topic for several writers, focusing on its problems as a significant topic for public debates. This was reflected by the appearance of newspaper articles, magazine accounts, and books on the concept of corporate governance (Wells, 2010). Two forces: the necessity of producing profit for shareholders, and the laws obliging corporations to pay income tax, made the fundamental

bases for managing earnings of corporations. Hence a challenge was shaped for managers to maximize profits while minimizing taxes at the same time (Grant, 2003).

The modern debates about the concept of corporate governance began with the 1932 publication of Berle and Means's book *The Modern Corporation and Private Property*, which drew the basic lines for the separation of ownership and control in modern corporations, and the problems accompanied with this separation. Berle and Means argued that the structure dealing with the governance of the corporations of the United States in the 1930s enforced the separation of ownership and control. They described the ownership of shareholders as owning shares in an entity called the corporate entity which is owned by corporate persons. They also studied the consequences of the separation of ownership and control. The implications of their work were clear. They advocated for voting rights for all shareholders, greater transparency, and accountability. One of the most important quotes in their book is:

“The property owner who invests in a modern corporation so far surrenders his wealth to those in control of the corporation that he has exchanged the position of independent owner for one in which he may become merely recipient of the wages of capital... [Such owners] have surrendered the right that the corporation should be operated in their sole interest” (Berle and Means, 1932: 355).

Wells (2010) argues that there were predecessors to Berle and Means who already discussed the issue of the separation of ownership and control. He also admits that Berle and Means' book *The Modern Corporation and Private Property* was the end product of several decades of trying to understand the problems associated with governance of modern corporations, and their impact on the nations' public. As a product of these debates, Berle and Means's (1932) work became a classic for corporate governance (Wells, 2010). It attracted the attention to the fact that shareholders are the legal owners of corporations. Berle and Mean's book was one of the building blocks for several codes and legislations (Nodoushani, 1996 cited in Grant, 2003).

The economic crash that occurred in the United States in 1929 and the unsuccessful efforts to limit the depressed economic situation that resulted from this crash resulted in the Security Acts of 1933 and 1934 (Grant, 2003). The main objectives of those two acts were to protect investors and fulfill their interests, and bring back the confidence in the stock markets. The 1933 Act aimed at regulating the initial security offerings of a company, and the 1934 Act aimed at regulating the secondary trading of these securities (Grant, 2003). Both acts required full financial disclosure, accompanied with a periodic financial statement to be filled by companies (McRitchie, 2002 in Grant, 2003). After the acts have been implemented, the 1934 Act established the Securities and Exchange Commission (SEC) to administer the regulations stated in the two acts. All companies that offer public stocks were obliged to register with the SEC.

It took up till the 1930s for the emerging concept of dispersed ownership to predominate in the United Kingdom, several years after the United States adopted this concept of joint-stock companies (Cheffins, 2001, 2002, 2004; Toms and Wright, 2002; Frank et al., 2004; Hannah, 1982 cited in Herrigel, 2006). In the 1950s, top managers of many US corporations began receiving stock options as a form of compensation. During the 1950s and 1960s, this form of compensation led to a new vision of managers to profit from their corporations. They showed a personal interest in boosting the profits and market values of the corporations' stocks (Lazonick and O'Sullivan, 2000).

The term corporate governance was first used in the literature by Richard Ells (1960) to indicate "the structure and functioning of the corporate polity". Polity is a particular form or system of government. Since there is no common code adopted by all corporations, it was since the birth of companies that a continuous search for best practices is pursued (Kostyuk and Braendle, 2007). So in a way or another, corporate governance existed since the corporate form used caused problems between owners and managers (Wells, 2010). In the United States, 'corporate governance' first became a trend in the language of business in 1970s (Cheffins, 2012).

Post the Second World War, there has been an era that extended till the 1970s in which workers of the United States were offered stable employment. There was a general improvement in the distribution of income

and profit in corporations (Piketty, 2013). There also has been a regulation to balance owner and manager powerbase and interests, also balancing them with a relative degree of power for the workforce via trade unions. This policy has led to a market dominance of workers to some fields of work through developing managerial experience and managerial learning (Lazonick and O'Sullivan, 2000). The 1970s in the United States saw the beginning of a radical change in the rise of shareholder values. The 1980s saw neo liberalism of society in the United States and a deregulation of business. There has been an increasing growth in the size of private corporate organisations through retention and reinvestment strategies in the 1980s and 1990s. Those strategies focused on activities which can lead to innovation and competition through hiring the highly educated personnel (Lazonick and O'Sullivan, 2000).

During the mid-twentieth century, many organisations in the United Kingdom were run in stakeholders' interests, rather than according to shareholder's interests and market needs. This happened although there were some efforts from the United Kingdom Parliament to offer relief to discontented minority shareholders through giving the courts some scope in this area. Nevertheless, this provision was rarely relied upon by the judiciary (Cheffins, 2001 and Herrigel, 2006). The stakeholder direction has declined since the 1980s, due to many reasons including the dispersal of stockownership and political attempts (Herrigel, 2006). In the 1980s, the measures taken by the United Kingdom Parliament offering minority shareholders easier access to the courts were reinforced and strengthened (Cheffins 2001).

A second stock market crash in the United States similar to the one of the 1929 took place in 2001. The crash occurred after the stock market made record gains in the 1990s. Once again, the crash led to the reopening of the large debates on corporate governance (Bianco, 2002 in Grant, 2003). The crash was in part a consequence of corporate mismanagement resulting in bankruptcies of many large companies like Enron Corporation and WorldCom. It also resulted in shareholder revolutions, and public distrust (Grant, 2003).

As a result of this second stock market crash in 2001 in the United States, an act given the name The Sarbanes-Oxley Act of 2002, also known as the

'Public Company Accounting Reform and Investor Protection Act', and as the 'Corporate and Auditing Accountability and Responsibility Act', was enacted by the US Congress on July 30, 2002. The act sets new or enhanced standards for all US public company boards, management and public accounting firms. It seeks to "protect investors by improving the accuracy and reliability of corporate disclosures made pursuant to the securities laws, and for other purposes" (The Sarbanes-Oxley Act, 2002: 1).

A financial crisis took place in 2007 and 2008. It was also known as the Global Financial Crisis and 2008 Financial Crisis. It has been considered to be the largest financial crisis since 1930s' Great Depression (Drezner, 2012). The United States Financial Crisis Inquiry Commission (2011) released a report on the causes of the financial crisis. The Commission described the crisis as avoidable, and specified its causes to be: the failures in financial regulations, including the Federal Reserve's failure to rectify dangerous mortgages; the breakdowns in corporate governance including too many financial firms acting impetuously, taking too much risk; excessive borrowing and risks by households and Wall Street; lack of preparation of key policy makers for the crisis, lack of full understanding of the financial system; and violations in accountability and ethics at most levels. Regardless of the shocks that were produced by this crisis, and that were more severe than those of the 1929 financial crisis, economic institutions and global economic governance structures responded quickly and vigorously (Drezner, 2012). For example, The U.S. Federal Reserve and central banks around the world took actions to expand money supplies. Central banks purchased 2.5 trillion U.S. dollars of government debt. A series of regulatory proposals were introduced by the United States President Barack Obama and key advisers in June 2009 addressing different aspects including consumer protection and executive pay (Obama, 2009; Geithner & Summers (2009; Treasury, U. S. (2009).

Again, the topics of bad decisions taken by senior managers, dealers, and bankers, and the lack of accountability to owners, shareholders, and other stakeholders were raised. The linking of major economic and financial crisis with corporate governance illustrates the wide implications of corporate

mismanagement and how its effects can go beyond harm to the principals and owners.

2.3 The Corporation

Mueller (2003) stated that the corporation we know today is the fruit of a process that began in the United Kingdom as early as the 17th century (Mueller, 2003 in Kostyuk and Braendle, 2007). Corporations existed in Europe and the United States since the early 17th century in the form of entities that worked for the service of the public good, like hospitals and universities (Grant, 2003 & Berle and Means, 1932). At that period, there were no markets for selling and exchanging ownership claims or shares (Larner, 1966 cited in Kostyuk and Braendle, 2007). As a result, shares were only transferred to relatives or friends, and therefore the control was described by 'voice' rather than by 'exit' (Hirschmann, 1978 cited in Kostyuk and Braendle, 2007). Voice in this context is a term used when any shareholder who was dissatisfied with the performance of the company in which he/she owns shares. He/she was only able to put verbal effort and patience into the company instead of selling his shares or transferring them. The sales or transfer of shares which was not possible at that time is referred to as 'exit'. In the United States, the rise of business institutions during the industrial revolution which occurred in the period from about 1760 to sometime between 1840 and 1860 was induced by a need for large amounts of capital (Clark, 2001 and Monks & Minnow, 2002 in Grant, 2003). The corporate revolution in the United States occurred between the 1880 and 1930 through significant changes in the ownership structure of industries which started evolving from private ownership to external ownership (Grant, 2003).

Up until the beginning of the 17th century, partnership was the only form of management for nearly all sorts of businesses. The origin of corporations having the form that we know today is England (Grant, 2003). The British East India Company which was frequently referred to as the 'John Company' was one of the first companies ever established, gathering investors to fulfill the demand of large projects. It was a joint stock company having 125 shareholders and a capital of £72,000 at the end of the 17th century. The

British East India Company was granted an English Royal Charter by Queen Elizabeth I at the end of the 1600s along with some trade privileges in India. It was an exception during that period, as corporations generally remained small until the beginning of the 19th century. Companies launched in the 16th and 17th centuries, similar to the British East India Company, were the Hudson's Bay Company, and the Levant Company (Cheffins, 2012). During that period, corporations only existed for a limited time and they were not allowed to own stocks in other companies. With the huge demand for giant firms at the beginning of the industrialization period, around the 1760's, the picture had changed to a large extent (Mueller, 2003 cited in Kostyuk and Braendle, 2007). Between the years 1895 and 1904, corporations were no more state-controlled in the US for example, but became private corporations with limited responsibilities and accountability. Here the 'exit' option became available for shareholders as the trading of shares became simpler. This exit decision in the market could be used to reflect the satisfaction or dissatisfaction of those shareholders towards the managers' actions, behaviours, and decisions. This was why considerable authority was given to managers at that time. Here, the control via the 'voice' option was transferred to the boards of directors of the companies knowing that those boards were usually dominated by managers themselves. Hence, the appearance of the separation of ownership and control was between the end of the 19th century and the beginning of the 20th century, almost 115 years ago. This separation was due to the shift of the control of corporations to managers. In 1844, an act was implemented to allow corporations to define their own purpose and objectives. A second act followed in 1854 giving shareholders limited liability to protect their personal assets from the failure of corporations, and to encourage investors by offering low risk investments (Grant, 2003). England and Holland were the first countries where corporations began to emerge in the form of merchant traders, when personal assets were traded for stocks in corporations (Grant, 2003).

According to Kostyuk and Braendle (2007: 5), any corporation is characterized by four key features, which are:

A separate legal personality: With its own legal personality, a corporation can be a party in a contract and also the subject of rights and liabilities. Moreover, the corporation will exist for an indefinite period, up until it is liquidated.

Separation of Management from Ownership: Shareholders which are sometimes called the owners of the company share the company's profits, if profits were to be distributed by the management which is separated from the shareholders. An agency problem arises because shareholders have limited liability and they have an inability to control the management. Despite this problem, separation enables the adequate and efficient functioning of the corporation by specialists. A separation occurs because managers may not possess capital and shareholders may not possess managerial expertise.

Limited Liability: In a company, the shareholders are not responsible for the losses, as the company is by itself responsible for its own debts and liabilities. At the same time, shareholders share the company's profits. Therefore, shareholders are only liable to the company by paying the cost of their shares at the beginning, but then they have no additional liabilities. This limited liability of shareholders increase the motivation of managers and shareholders to take risks, an action that may easily lead to inefficient use of resources. An example of this is how managers drive takeovers and acquisitions of similar industries, not adding much real value but allowing themselves to inflate their own salaries and to grow the business without large management risks.

Transferability: A share owned by a shareholder can be transferred to a new holder at any time, and by this, the new owner of the share will have the same rights and liabilities that the old owner had. Public companies usually trade shares through a stock exchange which makes this trade an easy and simple task for investment. Inevitably there will be some transaction costs for such a trade in stock.

2.4 Reports on corporate governance problems and resulting codes of practice

Ever since the collapse of the English companies Guinness (in 1986), Polly Peck (in 1990), Bank of Credit and Commerce International-BCCI (in 1990), and Maxwell (in 1991), corporate governance became a major concern for managers and owners of corporations, especially UK corporations. The reasons for the collapses were as follows: Guinness collapsed due to manipulation of the stock market on a massive scale to inflate the price of Guinness shares; Polly Peck collapsed because the CEO Asil Nadir was convicted of stealing the company's money; Bank of Credit and Commerce International-BCCI collapsed because of a breach of United States law, by owning another bank, in addition to fraud, money laundering and larceny; and Maxwell collapsed because Robert Maxwell had stolen hundreds of millions of pounds from his own companies' pension funds before his death. These business collapses, among other collapses in several different countries, led to a series of codes and reports aiming for the general enhancement of corporate governance practices.

Major codes of practice were published following these major business failures. Next is a list of the major resulting reports and codes, with a short description of their main focus:

The United Kingdom's Cadbury Report in 1992 focused on the financial aspects of corporate governance; the Rutteman Report in 1994 focused on the internal control and financial reporting for directors of listed companies registered in the UK (Rutteman, 1994); the King Report (I) of South Africa in 1994 focused on standards of behaviour for boards and directors of companies, banks, and certain state-owned enterprises (King Committee, 1994); the Toronto Stock Exchange recommendations on Canadian Board Practices in 1995 was concerned with role of the board in adopting a strategic planning process and ensuring the board functions independently of management, and the need for accounting expertise for audit committee members (Fabes, 2002); the Greenbury Report in 1995 focused on the level of director remuneration (Greenbury, 1995); the Viénot (I) Report of France in 1995 was mainly concerned with the board of directors of publicly listed

companies, aiming to make more effective boards' roles; the Netherlands Report in 1997 dealt with the management board, the supervisory board, the shareholders and the general meeting of shareholders, and the audit of the financial reporting and the position of the internal audit function and the external auditor (Corporate Governance Committee, 1997); the Hampel Report in 1998 aimed to combine, harmonize and clarify the Cadbury and Greenbury recommendations into a combined Code on Corporate Governance in 1998; the OECD Principles of Governance in 1999, as already discussed, covered the rights and equitable treatment of shareholders, the disclosure and transparency, the responsibilities of the board of directors, accounting and auditing, and adopting corporate governance codes in a company (Organisation for Economic Co-operation and Development, 1999); the Turnbull report in 1999 also known as the 'Internal Control: Guidance for directors on the Combined Code', informed directors of listed companies of their obligations regarding keeping good internal controls in their companies based on the combined code; the Viénot (II) Report of France in 1999 focused on director independence and the separation of the functions of the chairman of the board and the CEO; and the Myners Report in 2001 was a review of the Institutional Investment in the United Kingdom.

Another set of reports and codes has been endorsed after the stock market crash of 2001 in the United States, caused by the collapse of a series of US companies in 2001 including Worldcom which was considered as the largest bankruptcy in the history of the United States of America (Grant, 2003). The directors had used fraudulent accounting methods to push up the stock price. Similarly, in the Enron case, which was the seventh largest company in the United States, the directors and executives fraudulently concealed large losses in Enron's projects (Markham, 2006 & Cohen, 2012). This crash significantly raised the temperature of the international corporate governance debates.

Next is a list of the major codes following the stock market crash of 2001, with a short description of their main focus:

The King II South African corporate governance code in 2002, where new sections like responsibilities of directors, internal audit, sustainability reporting, role of board, and risk management were added (King Committee, 2002); the Sarbanes- Oxley Act in 2002 also known as the ‘Public Company Accounting Reform and Investor Protection Act’ and ‘Corporate and Auditing Accountability and Responsibility Act’ which is a United States federal law, seeking to “protect investors by improving the accuracy and reliability of corporate disclosures made pursuant to the securities’ laws, and for other purposes” (The Sarbanes-Oxley Act, 2002: 1); the Bouton report in 2002 which suggested improvements concerning the board of directors, accounting standards and practices, quality of financial information and communication, relation between company and shareholders, and the independence of legal auditors (Bouton, 2002); the Grant Thornton FTSE 350 Corporate Governance Review in 2002 which focused on many subjects including leadership, effectiveness, accountability remuneration and shareholder relations (Lowe, 2013); the Combined Code (revision) of 2003 which was derived from a review of the role and effectiveness of non-executive directors by the Higgs report and the independence of auditors and audit committees by the Smith Report (Smith, 2003); the Smith Report in 2003 which was concerned with the independence of auditors and audit committees (Smith, 2003); the Higgs Report in 2003 which was a revision of the role and effectiveness of non-executive directors in order to further strengthen the combined code (Higgs, 2003); the OECD Principles of Governance (revised) in 2004; the Turnbull revision in 2005; the Combined Code Revision in 2006; the Combined Code Revision in 2008; and the Financial Reporting Council (FRC) guidance on audit committees in 2008 which specified the role of the audit committee, its relationship with the board, its role and responsibilities, and its methods of communication with shareholders (Council, 2008). In this second period of reviews and codes, a clear focus on transparent accounting is evident, aiming to protect investors and principals from inadequate and fraudulent accounting and information.

A third set of codes and reports were endorsed after the global financial crisis took place in 2007 and 2008. These were: The King III South African

corporate governance code in 2009, where new sections like Information Technology governance, directors' responsibilities during mergers and acquisitions, evaluation of directors' and boards' performance, and shareholders' approval to non-executive directors' remuneration were added (King Committee, 2009); the EU green paper- Audit Policy: Lessons from the crisis in 2010; the UK Stewardship Code in 2010; the EU green paper – Corporate Governance in Financial Institutions in 2010; the UK Corporate Governance Code in 2010; the Davies Report- Women on Boards in 2011; the EU green paper- Corporate Governance Framework in 2011; the FRC Guidance on Board Effectiveness in 2011; the EU proposals- Reforming the audit market in 2011; the FRC Guidance on Audit Committees in 2012; the UK Stewardship Code in 2012, the UK Corporate Governance Code in 2014; the FRC Risk Guidance in 2014; the FRC Guidance on Audit Committees in 2016; and the UK Corporate Governance Code in 2016.

Codes and regulations have to be comprehensive and dynamic in order to face the cleverness of industries which tend to find ways to circumvent them. This was focused upon by Joseph Stiglitz in the following quote:

“The Sarbanes-Oxley law, which was passed in the aftermath of the Enron scandal to ensure better corporate governance and investor protection, has been critically weakened. The industry is clever – whatever regulations are imposed, it will figure out ways to circumvent them. That is why regulation has to be comprehensive and dynamic” (Stiglitz, 2010: 149).

All the above reports and resulting changes of code of regulation illustrate that corporate governance has never stopped evolving since the existence of the corporation. Simone Lowe, the chairman of the Grant Thornton Governance Institute has stated that:

“After more than two decades of evolving governance guidance in the UK, many of us may be wondering if there is anything left to improve. Our 2013 research shows the answer must be an emphatic ‘yes’. The economic, commercial and regulatory environments continue to change, and governance practice and guidance must keep pace” (Lowe, 2013: 3).

It can be inferred that the three sets of corporate governance reports and codes of practice were a result of failures in large corporations, or major

financial crises. This enormous activity in this aspect supports the fact that there is no single best model of governance functioning, but suggestions of the best acts can be made use of, in order to prevent future failures. More reports and codes of practice will be certainly published, making use of lessons learned because of failures that take place after the latest codes.

2.5 Theoretical approaches to the study of corporate governance

As stated by Dalton *et al.* (2003), agency theory dominates corporate governance research. Early corporate governance research primarily focused on internal governance, such as the relationship between a company's managers and shareholders, in order to address and understand the agency problem. Theories such as internalization theory and agency theory were developed for this purpose (Fliaotchev and Wright, 2011). Agency theory was used to understand the problem that is seen to lie at the core of all corporate governance research and practice, known as 'the agency problem'. The agency problem is concerned with the problems associated with conflicts of interests between managers and shareholders. It recognizes that there can be inherent issues in: the role and nature of ownership; the composition of the board of directors; the separation of the managers and owners/ shareholders; executive remuneration; and the role of the market in governance.

Corporate governance scholars have recently criticized the focus of corporate governance on agency theory. Some scholars suggested looking for a wider range of theoretical perspectives for the study of corporate governance, seeking perspectives that both theoretically complement and substitute agency theory (Daily and Canella, 2003). Daily and Canella (2003) also suggested a "multi theoretic approach" to corporate governance for perceiving the mechanisms and structures that might improve organisational functioning. For this approach they suggested studying the board of directors as being the most central, internal governance mechanism. They also referred to Johnson *et al.* (1996), and Zahra and Pearce (1989) in their proposition of the need for additional and contrasting theoretical perspectives to agency theory in order to explain directors' resource, service, and strategy roles. A broad view of corporate governance should take into account the

external governance mechanisms which according to Denis and McConnell (2003) are the external market for corporate control (the takeover market) and the legal systems, while they define the internal governance mechanisms as the board of directors and the equity ownerships structure of the firm.

In their article on the organisational approach to comparative corporate governance, Aguilera *et al.* (2008) described the classical approaches of corporate governance as a closed systems approach to organisations and proposed open systems approaches which “examine these organisational interdependencies in terms of the cost, contingencies, and complementarities of different corporate governance practices” (Aguilera *et al.*, 2008: 475). They described these three factors as practical approaches to analyzing the effectiveness of corporate governance in different organisational environments (Aguilera *et al.*, 2008). Corporate governance has distinct agencies with a role to play in its system. Those agencies include the law, the regulators, the boards of directors, the executive managers, the shareholders, and the public opinion. The balance between these agencies varies by location and time (Cadbury, 1999).

In terms of open system approaches, Mayer (2013) for instance, argued that the basic definition of corporate governance should be broadened to incorporate an extended view of whose interests are at stake when we consider the success or failure of corporate institutions (Mayer, 2013). In contrast to agency theory, stakeholder theory, first proposed in the book *Strategic Management* of R. Edward Freeman, describes how management can satisfy the interests of stakeholders (Freeman, 1984). Colin Mayer (2013), along with other management researchers, selects stakeholder theory as a primary theory for expanding corporate governance and gives it priority over agency theory.

Inter-relationships between stakeholders and other external factors were Mayer’s major concern regarding their effect on the internal governance of corporations. Freeman (1984) stated that “a firm’s decision should also be aligned with the interests of different players within and outside the company” (Freeman, 1984 in Jamali *et al.*, 2008: 444). Therefore, Jamali *et al.* (2008) suggested that firms should keep their activities adjusted to fulfill the needs

of society's ethical and legal desires. While a variety of studies have favored stakeholder theory of interpreting corporate governance, the findings of Jamali et al. (2008) on the synergies and interrelationships of corporate governance and corporate social responsibility challenge the usefulness of agency theory as the dominant paradigm in corporate governance research in favor of stakeholder theory.

When discussing corporate governance, two major theories discussed briefly above come into consideration: agency theory and its partisans, and stakeholder theory and its partisans. Other secondary theories are also to be considered: stewardship theory, resource dependence theory, transaction cost economics theory, and political theory. These theories were established based on different variables such as the arrangement of the board of directors, the independence of managers and their roles, the social relations of managers, and the audit committee (Nicolae and Violetta, 2013).

2.6 Agency Theory

Dalton et al (2003) stated that agency theory dominates corporate governance research. Agency theory was used to understand the problem that is seen to lie at the core of all corporate governance research and practice, known as 'the agency problem'. It is also concerned in studying the problems that arise when one party known as the principal delegates a job mission to another party known as the agent (Cheng, and Yeung, 2011). Agency theory analyses the conflicts occurring due to the agency relationship, described as

“a contract under which one or more persons (the principal(s)) engage another person (the agent) to perform some service on their behalf which also involves delegating some decision making authority to the agent” (Jensen and Meckling, 1976: 308).

The agency problem is concerned with the problems associated with conflicts of interests between managers and shareholders. It is described as arising within a firm whenever managers have incentives to pursue their own interests at the shareholders' expense (Agrawal and Knoeber, 1996) caused by the fact that shareholders have limited liability and have an inability to control the management. Claessens and Yurtoglu (2012) identify one cause

of this problem as being the multiple steps that separate shareholders from the final user of their capital. This theory recognizes that there can be inherent issues in the role and nature of ownership; the composition of the board of directors; the separation of the management and the owners/ shareholders; executive remuneration; and the role of the market in governance.

In his article on the origin of theory of agency, Barry Mitnick (2013) declared that the first scholars to propose the theory of the agency were Stephen Ross and Barry Mitnick in 1973. The first detailed description of agency theory was by Jensen and Meckling in 1976. Then the concept of the separation of ownership and control of this same theory was discussed more clearly by Davis, Schoorman, and Donaldson in 1997 (Abdullah and Valentine, 2009). According to Daily et al. (2003), two factors affect the prominence of agency theory. The first factor is that the theory reduces the firm to two parties, the managers and shareholders. The second factor is that the theory suggests that the managers always have self-interests. According to Eisenhardt (1989), agency theory has to deal with two problems of the agency relationships. The first is the agency problem caused by the conflict of interest between the owners and the managers, and the high cost of controlling the manager. The second is the preference of each of the principal and agent to different actions for the same risk. Figure 2.2 shows a simple scheme for the agency theory model.

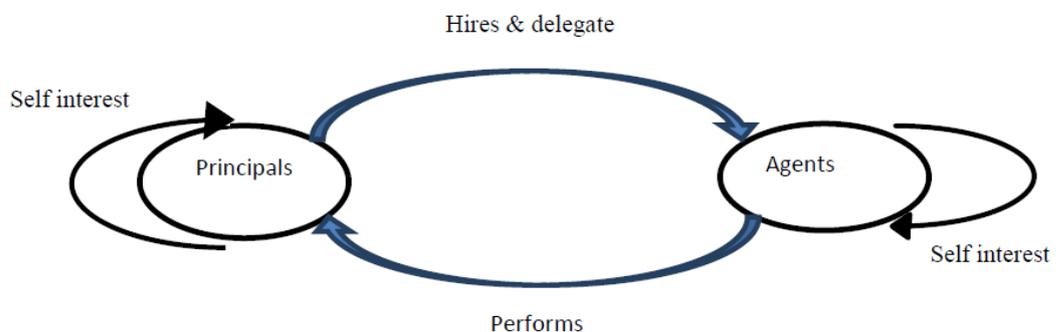


Figure 2.2 The Agency Theory Model

Reproduced from Abdullah and Valentine (2009: 90)

As seen in the figure above, the shareholders being the principals hire and delegate agents to perform in a way to protect and maximize their wealth and interests. The problem will be a conflict of interest between the principals and the agents, who both have self-interests in the firm.

2.7 Stakeholder theory

R. Edward Freeman explains his view to the purpose of the corporation's existence in his book *Strategic Management: A Stakeholder Approach* in 1984, by stating that a corporation exists for the purpose of serving its stakeholders (Freeman, 1984 cited in Grant, 2003). A stakeholder is any party that should be considered in the decision making process in any business. These include the management, the shareholders, the suppliers, the employees, the customers, the community, and even the competitors (Schilling, 2000 in Grant, 2003). Stakeholder theory suggests that the managers have a network of relationships known as the stakeholders which they have to serve.

Among the first researchers on the stakeholder's approach were Chester Bernard and Henry L. Grant who described the responsibility of the management to include the interest of stakeholders, and not only the shareholders (Wren, 1994 cited in Grant, 2003). In 1984, R. Edward Freeman published his book. After this publication, research on this field has grown exponentially, with lots of books and articles being published with a primary emphasis on the stakeholder approach to governance (Donaldson and Preston, 1995). Freeman (1984) and Pearce (1982) described a stakeholder as a person or group who have claim towards the firm (Freeman, 1984 and Pearce, 1982 in Argandona, 2011). Gareth Jones defines stakeholders as "people who have interest, claim, or stake in an organisation, in what it does, and in how well it performs" (Jones, 2010: 50). Stakeholder theory is known for its three aspects: its descriptive accuracy, its instrumental power, and its normative validity. All these three aspects are shown by Donaldson and Preston (1995) to be mutually supportive. Stakeholder theory's building block is the maximization of the value to stakeholders. The concept of creating value for stakeholders appears in a large amount of literature on stakeholder theory. According to March and

Simon (1958), each party of the stakeholders supplies the firm with a certain resource and expects its interests to be satisfied in exchange for this resource (March and Simon, 1958 in Hill and Jones, 1992). For example, shareholders provide the firm with capital and expect the firm to maximize the returns for this capital in return. Creditors provide the firm with capital too, and expect their loans to be returned on time. Managers and employees provide the firm with effort, skills, and human capital and expect decent working conditions and a fair income. Customers provide revenue for the firm and expect good products and services in return. Suppliers provide the firm with input and expect money in return (Hill and Jones, 1992).

Value is described as the benefit or the profit that the consumer or other stakeholder gets. According to stakeholder theory, this value is to be maximized. It should provide benefit to all stakeholders in one way or another. Stakeholders compete for this value created by other stakeholders, whether they have contributed to creating it or not (Argandona, 2011). Here, the value referred to by stakeholder theory should be distributed fairly through the direct or indirect involvement of all stakeholders in the decision making process of the firm. According to Argandona (2011), there are six types of value: the economic extrinsic value defined as the sum of the consumer surplus and the producer surplus; the intangible extrinsic value such as the recognition and training; the psychological intrinsic value such as satisfaction; the intrinsic value such as the acquisition of knowledge and capabilities; the transcendent value consisting of evaluative learning; and the value that consists of positive or negative externalities. These six types of value define the relationship between a company and its stakeholders. Figure 2.3 shows a simple scheme for the Stakeholder Model.

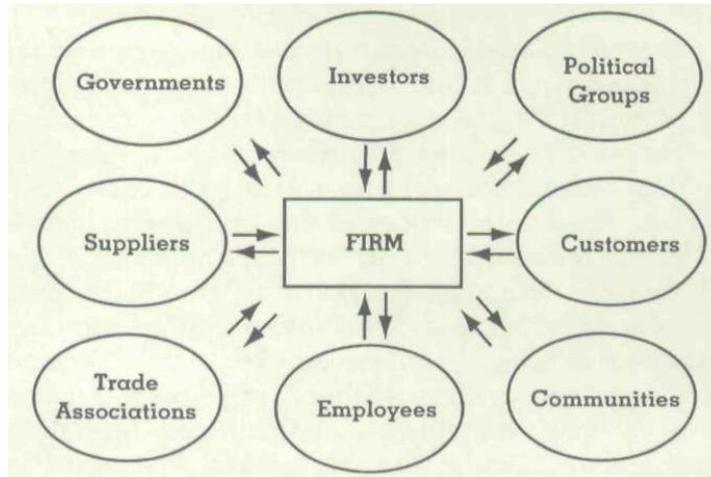


Figure 2.3 The Stakeholder Model

Reproduced from Donaldson and Preston (1995: 69)

The figure shows a symbiotic relationship between the firm and each of the investors, political groups, customers, communities, employees, trade associations, suppliers, and governments. All these entities constitute what is called *stakeholders*.

2.8 Stewardship Theory

According to the Oxford dictionary, a steward is a person employed to manage another's property, especially a large house or estate, or a person whose responsibility is to take care of something. Managers in this theory are considered as good stewards who should act in the interest of shareholders (Donaldson and Davis, 1991). Donaldson and Davis (1989) introduced stewardship theory as a means of defining relationships based upon other behavioural premises. Davis et al. (1997) referred to stewardship theory as having its roots in psychology and sociology, and specified that it was designed for the purpose of studying the situations in which the stewards may act in the interests of their principals. Unlike agency theory, stewardship theory stresses individualism in the way that trust helps in giving both jobs of the chairman and the CEO to the same steward. It also focuses on the act of integrating the interests and goals of the stewards with those of the organisation. Stewards in this perspective act as company executives who work for the interest of shareholders, by protecting and maximizing profits for shareholders (Donaldson and Davis,

1991). They are to be motivated and satisfied with organisational success (Abdullah and Valentine, 2009). Unlike agency theory which suppresses the motivation of an employee by considering him as a profit-being (Agyris, 1973 cited in Abdullah and Valentine, 2009), stewardship theory empowers the steward by offering him a large amount of autonomy built on trust (Donaldson and Davis, 1991). This theory focuses on self-evaluation by the stewards themselves, acting autonomously with an aim to maximize the shareholders' profits and the financial performance of the company. This gives stewards a protection for their reputation as decision makers (Daily, 2003 cited in Abdullah and Valentine, 2009), thereby making firm performance as the major factor for the perception of the steward's performance and reputation. One of the basics of this theory is a strong relationship between managers and the success of the firm (Yusoff and Alhaji, 2012). One of the major advantages of this theory appears in minimizing the cost of monitoring managers (Davis et al., 1997). Stewardship theory decreases the agency cost through increasing the role and power of the steward, by unifying the role of the chairman and the CEO in one person called the steward. It also decreases accountability issues through the trust given to the steward. This is supposed to give better safeguarding of the shareholders' interests (Abdullah and Valentine, 2009 and Clarke, 2004). This also makes the fate of the firm and the power of management in the hands of one person. Hence, this theory focuses more on the structure of the firm than on the management (Davis et al., 1997). Figure 2.4 shows a simple scheme for the stewardship model.

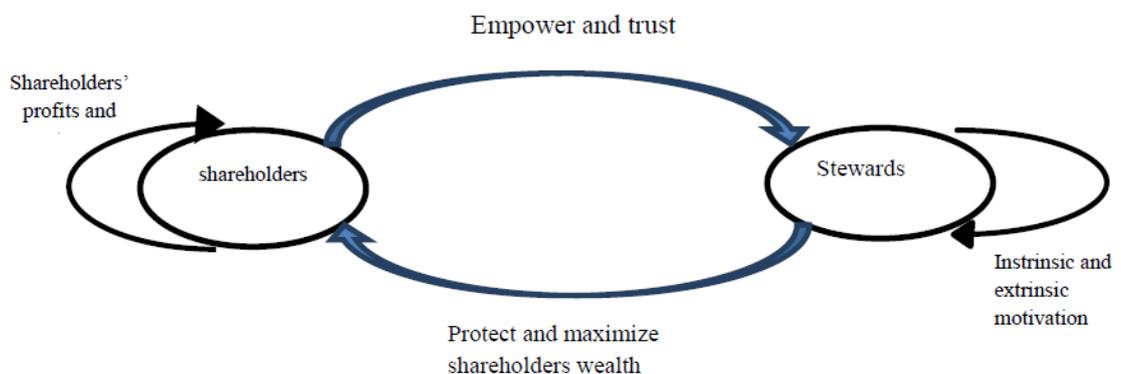


Figure 2.4 The Stewardship Theory Model

Reproduced from Abdullah and Valentine (2009: 91)

As seen in the figure above, the shareholders hire stewards to protect and maximize their wealth and interests. The major condition of this theory is that shareholders have to empower and trust the stewards. Stewards have intrinsic and extrinsic motivation, which usually act to the benefit of the firm in general.

The stewardship theory makes a very important contribution to corporate theory development as it emphasizes the importance of a social understanding of governance that examines trust and corporate and professional relationships.

2.9 Resource Dependence Theory

The provision of resources is a major building block for the success and adequate performance and functioning of firms (Daily et al., 2003). Resources include skills, information, legitimacy, access to suppliers, buyers, social groups, and public policy makers (Hillman, Canella and Paetzold, 2000). Mudambi and Pedersen (2007) referred to Pfeffer and Salancik (1997) in explaining the basis of resource dependency theory, stating that the control of resources that are strategic for an organisation provides this organisation with power. This power is usually expressed through budgets and resource allocation (Pfeffer and Moore, 1980 and Mudambi and Navarra, 2004). Resource dependence theory which was first discussed by Jeff Pfeffer in 1978 (Davis and Cobb, 2009), focuses on the role of managers and boards in providing access to distinct resources needed by firms (Abdullah and Valentine, 2009). Different authors refer to this theory in similar ways. For example, Hillman, Canella and Paetzold (2000) stated that resource dependence theory stresses the directors' role in securing the necessary resources to a firm through their external connections. On the other hand, Johnson et al. (1996) refer to this theory as focusing on hiring representatives of independent organisations as a way to get access to resources essential to the firm's success (Johnson et al., 1996). Abdullah and Valentine (2009) classified directors as fitting into four categories: insiders who are executives in the firm and provide knowledge in specific areas; business experts who are executives of other firms and provide skills

of knowledge on decision making, business strategy, and problem solving; support specialists who may be lawyers, bankers, insurance company representatives, and public relations experts and provide expertise each in his field; and community influentials who are political leaders, leaders of organisations, members of religious services, and so forth (Abdullah and Valentine, 2009). Resource Dependence theory became one of the major theoretical perspectives which explains why firms engage in mergers and acquisitions (Hillman, Withers, and Collins, 2009). It offers clear reasons of why firms acquire other firms (Haleblian et al., 2009). Mergers and acquisitions help reduce the threat of competition and as a result help control markets and raise prices. This may raise issues for the wider society and the public interest in stakeholder theory and this is why most governments seek to scrutinize mergers and acquisitions and their potential monopoly and future effect on the public interest.

2.10 Transaction Cost Economics Theory

Transaction cost economics theory is a pure economic theory first emerging in early 1970s as an economic concept, originating from contributions made by Commons (1934) and Coase (1937) in the 1930s on law, economics, and organisation (Williamson, 1989). It was described by Oliver Williamson for the first time in 1979 in his article “Transaction cost economics: the governance of contractual relations” in the *Journal of Law and Economics* (Hardt, 2009). The transaction cost economics program is the product of two complementary fields of economic research which are the ‘New Institutional Economics’ and the ‘New Economics of Organisation’ (Moe, 1984, 1990 in Williamson, 1998). In the 1990s, this theory started stressing the firm as an entity which creates positive value. Through this theory, “the firm is no longer only seen as an avoider of negative costs but also as a creator of positive knowledge” (Hardt, 2009: 29). Its main concept is based on the fact that contemporary firms are large organisations that enclose people with different views and objectives. These firms have become so large that they substitute for the market in determining the allocation of different resources (Abdullah and Valentine, 2009). This theory received considerable challenges in the 1970s and 1980s when it was argued that large organisations were often

inefficient because many of the specialist processes within them were no longer subject to market competition. Some argued that this inflated real costs and created inefficiencies. Therefore, some big corporations started to 'contract out' certain functions, getting contracts from other specialist businesses. In managerial terms, this process is called 'outsourcing'. Functions that were often contracted out included services like building maintenance, cleaning, payroll etc. Some very big corporations even split into smaller sub companies. Through this substitution, the firm itself can now determine the price and production descriptions of its products without major external interference. It can also save costs through performing tasks internally rather than depending on externals (Abid et al., 2014). Similar to the case of agency theory, transaction cost economics managers are described by this theory as being opportunists, arranging transactions to their own benefits and interests (Williamson, 1996). Nevertheless, large organisations that incorporate market competition argue that they can replace market value with other forms of social and human value that are reinforced by the large institution.

2.11 Political Theory

Political theory of corporate governance deals with the influences of political interferences in corporations. These interferences are based on politics rather than finance (Pound, 1993). They come in different forms, ranging from the participation of the government in the capital of firms and in laws that impose control of the government to firms (Nicolae and Violetta, 2013), to the change of corporate policies by investors themselves (Pound, 1993). Through the government's control, it participates in the corporate decision making, allocating corporate power, privileges, and profits (Abdullah and Valentine, 2009). Pound (1993) defines the political model of corporate governance as an approach in which

“active investors seek to change corporate policy by developing voting support from dispersed shareholders, rather than by simply purchasing voting power or control” (Pound, 1993 cited in Lynch-Fannon, 2003: 65).

This model of corporate governance has an enormous influence on the development of governance through the introduction of politics to the governance structure of firms (Hawley and Williams, 1996). It also discourages investors from investing in firms that are under the political control.

2.12 From Corporate Governance to Hospital Governance

According to Eeckloo et al. (2004), the principles of corporate governance need specific adjustments in order to be translated into the hospital sector, as the hospitals involve a large diversity of stakeholders and have an autonomy of different highly professional groups. Furthermore, they stated that corporate governance provides a 'frame of reference' to which hospitals can use for their governance.

According to Flynn (2002), hospital governance refers to the process of steering the overall functioning and effective performance of a hospital, by defining the hospital's mission, setting its objectives, and supporting and monitoring their realization at the operational level.

Hospitals have evolved in the last decades, increasingly revealing competitive behaviours. An increase in the scales of hospitals has been observed because larger hospitals usually have lower costs and better patient outcomes, as clinicians have the chance to experience a larger volume of cases (McKee and Healy, 2002). As a result of the increase in the scale of hospitals, more staff are being employed, and an increase in financial responsibilities are resulting. With all the competition that these hospitals are facing, they are evolving from supply organisations to demand and patient-driven institutions (Eeckloo et al., 2004).

Until lately, hospital governance was about managing the structure and infrastructure of a hospitals' departments. Nowadays there is an increase of interest in quality and safety measurements, along with the fulfillment of stakeholders' needs. So the "essence of hospital governance will be managing processes and supporting care activities, with health gain being the key assessment criteria" (Eeckloo et al., 2004:2).

There are differences between corporate governance recommendations of for-profit organisations and non-profit hospitals. In for-profit organisations,

there is a well-defined relationship between the owners and the managers, constituting the basis of the corporate governance concept. The relationship is usually known as the accountability of managers and the board of directors to the shareholders of the firm. On the contrary, non-profit hospitals have no real owners, and hence the significance of the shift from the shareholders to the stakeholders of the hospitals. Moreover, for-profit organisations aim for the maximization of profit, which lacks in non-profit hospitals.

In both for-profit and non-profit organisations, a common governance problem is that the leaders will have no immediate hierarchical superior, and hence the importance of setting adequate corporate governance structures that aid in minimizing the risks of failures or acts of conflicts of interest in both forms of organisations.

2.13 Hospital Governance

Hospital governance is one of the various forms offered by the term 'governance' which is used for example in corporate governance, clinical governance, cultural governance, social governance, E-governance, global governance, and government governance. Specialism in different sectors is an important development in corporate governance to ensure that governance matches sector context and requirements. There is even the type 'football governance' mainly used in the United Kingdom, and constituting a research centre in the University of Birkbeck in the United Kingdom known as the Birkbeck Football Governance Research Centre (FGRC) (Football Governance Research Centre, 2015). This research focuses particularly on 'hospital governance'. Hospital governance refers to "the complex of checks and balances that determine how decisions are made within the top structures of hospitals" (Eeckloo, 2007:1).

Corporate governance research has tended to focus on a narrow category of for-profit organisations. Extending corporate governance theories to include not-for-profit organisations was problematic due to its previous focus on return on shareholder investment. In a study done by Eeckloo *et al.* (2004) on 82 hospitals in Belgium, they stated that "there simply is no such thing as 'the' corporate governance model" (Eeckloo *et al.* 2004: 4). They broadened the definition of corporate governance referring to the Cadbury Report of

1992 by describing it as “the system by which companies are directed and controlled” (Eckloo et al., 2004: 3). They described how corporate governance usually has a qualitative essence and therefore it can become a general description for all types of rules and guidelines needed for the optimization of the firms’ governance structures. They also broadened the question of ‘to whom’ the study of corporate governance is relevant by saying it is concerned with preserving the interests of any person who is affected by a firm’s achievements – effectively the firm’s stakeholders (Freeman, 1984 and OECD, 1999).

‘Hospital governance’ is a specific category of corporate governance developed in relation to hospitals (Eeckloo *et al.* 2004). It is also defined as the structures and processes defining the hospital’s mission, vision, values, and goals; and defining the means by which the hospital’s resources, including the human resources, technological resources, political resources, and capital and other financial resources are allocated for the purpose of achieving its aims (Eeckloo, 2007). In contrast to corporate governance, hospital governance is described by Eeckloo *et al.* (2004) as having a more institutional approach. They defined it as being the process of navigation through the functioning and effective performance of hospitals. Its main function is to define the hospital’s mission, set its objectives, and support and monitor their implementation. It is described as concerned with the “structuring and functioning of the governing bodies of hospitals” (Eeckloo *et al.* 2004:2). Its function is to provide an integrated approach of supporting and supervising all hospital activities, including clinical performance.

In healthcare contexts, it is recognised that there is a close interaction between corporate governance and clinical governance. Jamali *et al* (2010) described clinical governance as being focused on governance in the clinic or hospital, while corporate governance has a wider scope focusing on corporations in general. They use Braithwaite and Travaglia’s (2008) quotation explaining that clinical governance is more involved in “planning and organizing governance structures for safety and quality; and sponsoring a patient focus” (Braithwaite and Travaglia, 2008:13). In order to extend their definition for clinical governance, Jamali *et al* (2010) referred to Braithwaite and Travaglia (2008), and Balding (2005) who state that:

“the central objective of a sound clinical governance system is to ensure that the quality and safety of medical services and procedures are the main drivers for healthcare institutions, operations and performance, with a focus on patient outcomes”(Braithwaite and Travaglia, 2008;Balding, 2005 cited in Jamali *et al*, 2010: 593).

They referred to Duckett (2007) in arguing that clinical governance also encourages more participation of clinicians and patients in the governance itself (Duckett, 2007 cited in Jamali *et al*, 2010). Jamali *et al*. (2008) identified the continuous refinement of “laws, regulations, and contracts that govern companies’ operations”, maintaining a “transparent environment” to ensure that rights are protected and there is an alignment between owner and mangers’ interests in order to maximise growth and value creation (Jamali *et al*., 2008:5).

Many factors drive the operational and managerial processes in hospitals to change. These include the evolving technologies, the advances in medical and clinical research and knowledge, the financial problems, and the expectations of the public and the patients. All these factors result in pressures on the traditional managerial systems. Managerial systems should continuously evolve in order to adapt to their entourage and maintain equilibrium. This process in physiology is referred to as ‘homeostasis’. Homeostasis is a physiological property of bodily states to stabilize, regulate, and maintain their internal environment under equilibrium (Langley, 1973 and Cooper, 2008). A similar concept takes place in the organisation. Eeckloo (2007) described this concept as an ‘organisational homeostasis’, and he characterizes it as an ongoing process.

After discussing the recent developments in some European countries, Eeckloo (2007: 83) stated that “no uniform scenario, or route map for governance reforms, applicable to all hospitals in all European healthcare systems, is available (nor would be useful)”; a similar concept to what Eeckloo *et al*. (2004) described in stating that there is no such thing as ‘the’ corporate governance model. This notion will be logically applicable to all hospitals because hospitals are largely influenced by the evolving healthcare system which they are part of.

In their book *Innovations in health service delivery: the corporatization of public hospitals*, Preker and Harding (2003) split the governance in the health sector into four levels. The first level is the global (or cross national) level. Procedures addressing international pandemics are an example of this level of governance. This would include the role and work of organisations like the World Health Organisation (WHO). The second level is the multi-sectoral (or 'macro') governance which deals with the policies controlling the use of resources in the broader economy of a nation. Third is the sectoral (or 'meso') governance in which the Ministry of health protects and promotes health through imposing policies and allocating resources among the different parties that are under its control, including the technology and pharmaceutical product sellers and producers. The final level is the institutional (or 'micro') governance, dealing with the control of specific organisations' resources, such as hospitals, pharmaceutical companies, and health insurance plans (Preker and Harding, 2003). This research will be dealing with this fourth level of institutional governance, specifically with the governance of hospitals.

Hospitals are considered to be complex service providers, seen as production functions, sets of technological and bio-pharmacological capacities, data-processing machines, and the providers of complex services and healthcare system hubs (Djellal and Gallouj, 2005). Eeckloo (2007) describes them as more complex than most other organisations. He also describes the decision making process as much more diffuse than in most other organisations, making the transaction outcomes of hospitals less transparent and more difficult to assess.

In their famous article 'Managing the care of health and the cure of disease', Glouberman and Mintzberg (2001 a) described the management of hospitals as several distinct processes instead of one homogeneous process. They used the analogy of 'four worlds' of the hospital: the world of cure, the world of care, the world of control, and the world of community. These worlds are based on where the management is practiced. They differentiated these different worlds by four quadrants of activity in the hospital, as seen in figure 2.5, with *down*, *up*, *in*, and *out* directions.

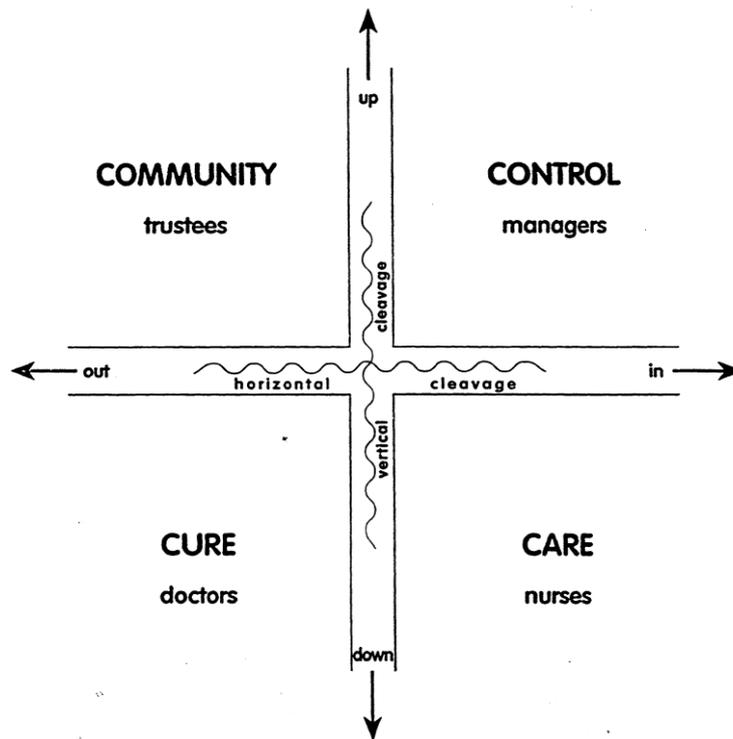


Figure 2.5 Four Worlds of the General Hospital

Reproduced from Glouberman and Mintzberg (2001-a: 3)

Some managers manage *down* into clinical operations by focusing on the treatment side. Others manage *up* into the control and funding. On the other hand, some management is applied into the control of the hospital, and others are applied *out* into those who are involved but technically independent from the formal authority of the hospital. As already stated, the four quadrants of activity in the hospital are constituted of: the world of cure, the world of care, the world of administrative hierarchy, and the world of trustees.

The world of cure present in the bottom left quadrant consists of the medical community, including medical doctors, and functioning through arrangements of medical chiefs and committees. Those in this quadrant manage *down* into the operations, and *out* as the doctors and do not report into the hierarchy of the hospital. The world of care supporting the world of cure consists primarily of nurses and other specialists who provide basic care. It is present in the

bottom right quadrant of activity. The management of nursing and other basic care is described as *in* and *down* since it connects directly to the hospital administration and focuses on the treatment of patients. The world of control which is the management of the hospital, specifically, is found in the upper right quadrant, with an *in* and *up* position since the managers are in control of the entire hospital, and at the same time they are not involved in clinical operations. Finally, the world of community present in the upper left quadrant represents the shareholders and trustees of the hospital. They are *up* and *out* because they are neither involved in clinical operations, nor under control of the hospital (Glouberman and Mintzberg, 2001-a). With these different quadrants, the hospital ends up having four organisations in one hospital, each structuring itself independently. It is clear that this model promotes the agency problem considerably (Eeckloo, 2007). As seen in figure 2.5, there are two cleavages in the system: a horizontal cleavage separating those who are clinically involved (*down*), such as doctors and nurses, from those who are not, such as trustees and managers; and a vertical cleavage separating those who are administratively involved (*in*), such as managers and nurses, from those who are not, such as trustees and doctors (Glouberman and Mintzberg, 2001-a). The model presented by Glouberman and Mintzberg has been well-known in the second half of the twentieth century. Despite the problems resulting from it, this model potentially brings security and stability to the governance of hospitals (Eeckloo, 2007).

In discussing the management of health care, Glouberman and Mintzberg (2001-b) stated that the management at the institutional level and at the system level, likewise, has to change in a way to become less opaque, more direct, more involved, and natural. They also referred to the four worlds of the general hospital they previously proposed, in order to suggest that practitioners should have a greater appreciation to the managerial process, and similarly, the managers and the trustees described as community representatives should have a better deeper understanding of the clinical operations taking place in their hospital.

This research study will be dealing with the institutional (or 'micro') governance of the upper side of the horizontal cleavage with the vertical cleavage separating the managers from the trustees and

owners/shareholders. It will also deal with the relationship of the hospitals with their stakeholders.

The composition of the boards of directors of hospitals varies with different ownership types and organisational forms. Different ownership types are categorized according to private and governmental ownership, including for-profit and non-profit hospitals, and constituting government, religious, district, and teaching hospitals (Eldenburg et al., 2001). Structures of hospital governance aim to ensure the maximization of efficiency at the hospital. Efficiency is obtained by maximizing the objective function of the hospital. This objective function differs between for-profit and non-profit hospitals. It is common that the objective function of for-profit hospitals is to maximize profit or value (Alexander, 1986). On the other hand, the objectives of the non-profit hospitals are still under-researched and are known to vary. Due to this variation in objectives, different governance structures evolve, ensuring the achievement of the different objective functions. In this context, Eldenburg et al. (2001) have found that boards vary significantly across different hospital organisational forms.

Although a difference exists between the objective functions of hospitals leading to different governance structures, the general governance function is still the same: boards of directors oversee managers' actions. Moreover, all hospitals perform the same jobs and offer the same basic services under standard methods. Therefore, any difference in governance cannot be justified by differences in products and methods, but in differences in objective functions (Eldenburg et al., 2001).

Among other secondary factors, the form of governance adjusts according to the organisation's performance. Moreover, the organisation's performance is directly affected by the governance of the organisation. Hence, this is a two-way process dealing with the governance and the performance of the organisation (Eldenburg et al., 2001). This process has been studied by all of Demsetz and Lehn (1985), Hermalin and Weisbach (1988), Brickley and James (1987), Denis and Sarin (1999), Shivdasani and Yermack (1999), Baker and Gompers (2000), Kroszner and Strahan (2000), proving that performance does, indeed, change governance, and governance does change performance, making it an interactive relationship.

Since the end of the 1980s, there has been a growing focus on outcomes and performance management, especially on both concepts of management; by objectives and performance management because there has been a focus on the relationship between the causes of management and organisation problems and performance. For these reasons, there must be a focus on performance measures and indicators. Hughes (1998: 63 cited in Haynes, 2003) stated that “Agencies are expected to develop performance indicators as a way of measuring the progress the organisation has made towards achieving declared objectives”. There is a direct relationship between performance management and the concept of management by objectives. Both models focus on the separation of *means* from *ends*, and *processes* from *achievements*. They both aim to isolate the *results* of management from the *processes* and *activities* of management.

As described by Haynes (2003), staff in any organisation or company must be effective. It is not enough for staff to be very active if they are not focusing their activity on agreed outputs and outcomes. It is essential for staff to understand the difference between activities and achievements. For example, the activity of a surgeon is the operations, but his achievements are health gain and quality of life improvement. An output is a numerical measurement of an achievement; in this case, it is the number of successfully performed operations. On the other hand, an outcome is a long-term view of an output, checking the later impact of an activity. In our example, it is reflected by the quality of life benefits that result from an operation.

Outputs and outcomes are the results of activities. There should be a clear definition and understanding of activities in order to be able to clearly assess outputs and outcomes. An example would be that doctors’ or nurses’ activity leads to an output such as the prescription of a medicine, which may result in an outcome of a healthier and satisfied patient. Similarly, activities are based on the presence of inputs. Examples of input would be human resources, training, and materials.

Therefore, as a summary, input leads to activities which lead to outputs and outcomes as results. The transition between an activity and an output is

based on the process which defines the output whether it makes a positive outcome or not.

2.14 Governance in non-governmental organisations

According to the handbook of NGO governance by Wyatt (2004), non-profit governance is based on the following basic constituents that identify real non-profit organisations: NGOs are accountable to their communities and they must have the highest level of accountability in this aspect, with good governance being a basic form of accountability; good governance has a formal structure which is a necessity as in other forms of for-profit organisations where the board is the principal governing body that makes its decisions collectively; good governance involves the separation of control and management, as in the case of for-profit organisations; NGOs are mission-based organisations and a basic role of the board is, amongst others, to safeguard and implement the mission of the organisation through effective planning and regular evaluation; NGOs must promote the highest professional and ethical standards; and finally, NGOs must be responsive to the communities they serve and work on obeying the communities' needs in the field that the NGOs are serving.

2.15 Clinical Governance

With the rise in clinical problems associated with a lack of safety and quality measures in the healthcare system, there has been a need to improve the quality and accountability of clinical care. Hence, the concept of clinical governance came into reality. According to Mannion and Davies (2002: 68), "clinical governance reflects a move away from professional regulation to more explicit framework for monitoring and improving quality" and "the clinical governance agenda is analysed using the principal-agent framework".

2.15.1 A principal-agent perspective: the context of clinical and corporate governance

Although corporate and clinical governance concepts are related, they have different connotations (Eeckloo, 2004). Nonetheless, clinical governance is a subcategory of corporate governance in the clinical or hospital context, as “clinical governance is utilized to strengthen links between the health services, clinical, and corporate governance arenas” (Travaglia et al., 2011: 63). The relationship of clinical governance to corporate governance is based on a principal-agent perspective. According to Eeckloo et al. (2007), the agency problem can be easily understood by looking at two examples: corporate governance and clinical governance. As the corporate governance deals with relationships based on the extent to which the agent is accountable to the principal, clinical governance is about ensuring that healthcare professionals, as ‘agents’ within the healthcare system, are accountable for their practice, while at the same time respecting the professional autonomy of the individual physicians and other healthcare workers (Mannion and Davies, 2002).

2.15.2 History of Clinical Governance

Clinical governance emerged as a result of a process of improving the National Health Service (NHS) of the United Kingdom. The NHS is the publicly funded national health system of England. It was founded in 1948 and is the largest and oldest single-payer healthcare system in the world.

Since its establishment, the NHS did not have a particular plan for quality. It was considered that through availability of appropriate infrastructure and training and education of staff, quality would result ultimately (Nicholls et al., 2000). For more than 40 years, the NHS implemented an implicit concept of quality, based on a conviction that the availability of well-trained staff, good facilities and good equipment are enough to provide the recommended quality in the healthcare system. Then clinical governance became a concept for describing a means for bringing about continuous quality improvement in the health system. Nowadays, clinical governance has become better known in several countries, but is not properly implemented in most of them.

In the 1970s, components of quality (criteria, standards, norms, etc.) were defined (Donabedian et al., 1982). In the 1980s, quality was still not separate in terms of its own management, but managers were always accountable for all output measures, and quality was subsumed under the heading of organisational performance. Then came the period where the involvement of clinicians in reforms and governance processes was proven to be essential in the health and quality management (Braithwaite and Travaglia, 2008).

In the 1990s, with the rapid development of health technologies, and with the improvements of clinical managerial methods, an increased complexity of management systems had evolved. This complexity required clear and consistent quality of healthcare.

2.15.3 Quality

According to the Oxford Dictionary, quality is defined as “the standard of something as measured against other things of a similar kind; the degree of excellence of something”. In the healthcare sector, quality is defined differently by both patients and professionals, including clinicians and managers. Clinicians for instance define quality as “doing the right things, for the right people, at the right time, and doing them right first time” (Birch et al., 2000: 25).

With the increase in error rates and adverse events, it has been noticed through studies in Australia and Canada that these events are causing a resistance to the policies and managerial efforts to reduce them (Wilson et al., 1995; Baker et al., 2004). This sheds light on the fact that quality and safety problems cannot be ignored and should be taken very seriously. In their book on safety and ethics in healthcare, Runciman and Walton (2007) drew a comparison showing that if a jumbo jet full of passengers crashes each week, there will be immediate rectification actions to solve the issue causing the crashes; while on the other hand, more people are injured and die each week because of the lack of quality and safety measurements provided in the healthcare systems; but these patients are injured and die one at a time, unlike the case of jet crashes. This is one argument for why quality and safety were not given the adequate attention that they should have been given.

2.15.4 Rise of Clinical Governance

In 1997, quality has become a “prevailing purpose rather than a desirable accessory” (Donaldson and Donaldson, 2003: 209). It was then when the English government introduced the real concept of ‘clinical governance’ to be used for quality, and which was previously only applicable for financial purposes as a governance concept. Clinical governance has become “the main vehicle for continuously improving the quality of patient care” (Scully and Donaldson, 1998: 61). It is a system which provides organisational reforms for delivering sustainable, accountable, and patient focused quality of healthcare (Nicholls et al., 2000). It represents the efficient signing up of activities to enhance quality. It brings together managerial, organisational, and clinical approaches for the improvement of the quality of healthcare. In fact, clinical governance framework is “a set of initiatives designed to enhance care, and the promotion of a productive culture and climate within which care can thrive” (Braithwaite and Travaglia, 2008: 11). It offers opportunities to understand how to build up the central parts required for facilitating the delivery of the quality of care (Halligan and Donaldson, 2001). In 2001, the Office of Safety and Quality in Health Care in Western Australia defined clinical governance as

“a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes” (Western Australian Department of Health, 2001: 2).

The delivery of clinical governance includes approaches to leadership, strategic planning for quality, involvement of patients, analysis of information, staff management, and process management. It enforces a change in the traditional view of roles and relationships between clinicians, patients, and managers (Halligan and Donaldson, 2001), similar to how new theories enforce the change of the corporate governance’s traditional view of the principal-agent theory.

Clinical governance is closely related to corporate governance. Corporate governance in general is concerned with the efficient running of corporations, the effective management systems, the production of good financial returns,

the direction and control of the boards of directors, the decision making processes and power, the implementation of ethical standards in running the companies, and the accountability of agents to principles and of the corporation to all stakeholders. Clinical governance, on the other hand, is part of the corporate governance system that directs the running of corporations. It is concerned with accountability, effective end results, availability of resources and their appropriate use, and adequate ways of technical processes and performance on the clinical level.

2.16 Conclusion

As we can see above, corporate governance theories neither contradict nor relate to each other in general. So adapting one or several theories is a matter of being convinced that one theory, or a combination of different theories, and provides an adequate means of describing governance of a firm.

The theories described above are the fundamental theories of corporate governance, differing in importance and adoption in the literature. Other theories may be associated to corporate governance. These include business ethics theory, virtue ethics theory, feminist ethics theory, discourse ethics theory, postmodern ethics theory (Abdullah and Valentine, 2009), legitimacy theory, and social contract theory (Yusoff and Alhaji, 2012). These theories' importance lie in the ways shared values and collaboration and partnership can reduce conflict between the principal and agent. Moreover, the information asymmetry theory or the theory of efficient markets is also sometimes referred to when discussing corporate governance (Nicolae and Violetta, 2013).

Taking into account recent criticism of corporate governance research that looks only at the internal governance structures of the firm through the lens of agency theory, I argue that there is still value in agency theory based approaches. However, whilst this research would focus on the internal relationships relevant to agency theory it would give some theoretical attention to the external factors relevant to hospital governance in Lebanon. Therefore, based on the literature review and on the gaps in the literature,

this research study aims to answer the following research questions that are focused on the hospitals under study:

- 1- What is the nature of the agency problem in hospital governance?
- 2- How and to what extent does governance vary between hospitals?
- 3- What are the key measures of hospital performance?
- 4- In what ways are the managers and clinicians incentivized?
- 5- How and to what extent do external factors influence internal hospital governance?

Chapter 3

METHODOLOGY AND METHODS

3.1 Theoretical conceptual framework

Corporate governance is a phrase that reflects management mechanisms and practices taking place inside corporations and their results on the performance and behaviour of managers and managing teams on one hand, and on the shareholders, owners, and financing agents on the other hand. It is also the relationship through which external stakeholders are involved in performance and behaviour. As the previous chapter showed, management researchers have tended to separate management from its resulting behaviours. They have also tended to study the organisation as a closed system from a positivist position using quantitative research methods. These assumptions are typical of a classical scientific approach to management research.

In his book *Images of Organization*, Morgan (1997) talked about classical management and scientific management arguing that classical management theorists described management in terms of the design of the organisation, while scientific managers focused on the design and management of individual jobs. Classical and scientific management can be understood as social science research, in which a structural-functional framework is applied by managers in order to master and control events. Scientific management theories are historically positivist and consequently explored through quantitative methods. Neuman (2006) describes positivist research methods as follows.

“Positivist social science is an organized method for combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity” (Neuman, 2006:82).

From another point of view, since management is a social science dealing with human behaviour, and since it is not a natural science (example: physics, chemistry and biology), it has to adapt to each organisation's situations and circumstances. It is contextual. Hence, from this point of view,

researchers have argued that management can also be understood from an interpretive social science position. According to this approach, the focus of different research studies is on the description of how situations are created by human interaction along with some focus on adaptability and differing organisational and social contexts.

Quantitative work gives a degree of coverage of comparative material and some ability to generalize across the staff groups that were surveyed. On the other hand, behavioural aspects which are qualitatively studied potentially offer a different view of the phenomenon being studied. From my point of view, behaviour in corporate governance can be seen to fall into three categories. The first one is the view that managers and management teams, shareholders, owners, and financing agents have of their own behaviour directed towards themselves, including the satisfaction they experience in fulfilling their duties. The second category is the behaviour of these entities directed towards their firm, including the requirements for them to fulfil their duties, respect the laws, and execute the corporate social responsibilities that the firm adapts. And the third behaviour is their behaviour directed towards each other, including their behaviours towards each other's interests and goals. These different behavioural views reflect methods for designing the qualitative research conducted in this study.

3.1.1 Critical Realism

In his book *Philosophy, science and social inquiry*, Denis Charles Phillips described realism as “the view that entities exist independently of being perceived, or independently of our theories about them” (Phillips, 1987: 205). On the other hand, Schwandt describes scientific realism as

“the view that theories refer to real features of the world. ‘Reality’ here refers to whatever it is in the universe (i.e., forces, structures, and so on) that causes the phenomena we perceive with our senses” (Schwandt, 1997: 133).

In the social sciences, the most common form of realism is ‘critical realism’ usually associated with the work of Roy Bhaskar, mainly in his publications of 1978, 1989, 1998, and 2011. Critical realism is a philosophical approach that combines the general philosophy of science with the philosophy of social

science, to illustrate a crossing point between the natural and social worlds. Roy Bhaskar was the first to describe the concept of critical realism although he did not initially use its term; instead, he used the terms 'transcendental realism' associated with the general philosophy of science and 'critical naturalism' associated with the philosophy of social science. Bhaskar then adopted the term 'critical realism' which is believed to be first used by Campbell (1974) to refer to the link between ontological realism and epistemological relativism (Denzin and Giardina, 2008).

Different theoretical frameworks have emerged for mixed methods research. Critical realism is one of the most widely used paradigms, seen as a midpoint between positivism and interpretivism (Mingers, 2004; Venkatesh et al., 2013). It helps in better understanding the significance and meaning of the subject being studied (Bhaskar, 1978) by supporting the idea of reality independently of one's perception of it (Archer et al., 2013; Bhaskar, 1978). Crow et al. (2014) explained that most of the previous research on governance has experienced difficulty in attributing causality to governance. They suggested an alternative approach to enable researchers to move beyond the limitations of positivism and interpretivism. This approach lies in the use of the methodology of critical realism that allows new knowledge to be gained about governance mechanisms. They see that the use of critical realism enables a shift in governance research beyond correlations. Moreover, Crow et al. (2013) also encouraged the use of critical realism, being a philosophy of social science, as an alternative philosophy to explore governance mechanisms and relationships between governance and performance.

Different versions of realism that are compatible with the major concepts of critical realism were studied, providing additional perspectives for the use of realism in qualitative research. Those included 'critical' realism (Archer et al., 1998; Bhaskar, 1989; Campbell, 1974, 1988; Cook and Campbell, 1979), 'experiential' realism (Lakoff, 1987), 'constructive/ perspectival' realism (Giere, 1999), 'subtle' realism (Hammersley, 1992), 'emergent' realism (Henry et al., 1998; Mark et al., 2000), 'natural' realism (Putnam, 1999), 'innocent' realism (Haack, 1998, 2003), and 'agential' realism (Barad, 2007).

These different forms of realism prove that there is no single or exact theoretical understanding of the world (Maxwell, 2012).

Social sciences deal with the human world which is fundamentally different from the natural sciences dealing with the physical world. Hence, we should adapt our strategies for studying each of these worlds, in order to get the most efficient results. After Roy Bhaskar popularized the theory of critical realism in the 1970s, it became one of the major trends of social scientific methods, competing and taking the place of positivism- empiricism, post-structuralism, relativism, and interpretivism. It is believed that realism can give valuable results when implemented correctly for qualitative methodology, although it may not be stated that realism is the 'best' or 'correct' philosophical position for qualitative research. On the other hand, a realist perspective offers useful ways of approaching problems and produces clear perceptions of social phenomena when studied quantitatively. Ontological realism is often used by critical realists, with an openness and acceptance to epistemological constructivism and relativism. Ontological realism is based on a real world that exists independently of human's perceptions and theories, while epistemological constructivism and relativism are based on the human's understanding of the world; this understanding being a construction from their own perspectives (Maxwell, 2012).

There is a noticeable difference between critical realism and positivism in many ways. The primary difference is the joining of critical realism to ontological realism and epistemological constructivism, distinguishing it from both positivism and empiricism. Theoretical concepts which are the basis for positivism are rejected by realists (Phillips, 1987). Theoretical terms adopted by positivism are based on logical observations used to make predictions (hypotheses) which according to realists do not have direct relation to any reality. This view is often referred to as 'instrumentalism' (Dewey, 1994).

Critical realism bases its philosophy on a single reality, rejecting multiple realities. This vision can be seen by Edward Sapir's known statement:

"The worlds in which different societies live are different worlds, not merely the same world with different labels attached" Sapir (1958: 69).

Critical realism is known to locate causal relationships at the level of generative mechanisms, while positivism and empiricism are located at the level of events. A *mechanism* is the

“way of acting or working of a structured thing....Structured things [physical objects or social processes] possess causal [or emergent] powers which, when triggered or released, act as generative mechanisms to determine the actual phenomena of the world” (Lawson (1997: 21 cited in Zachariadis et al., 2011).

The stratified ontology of critical realism is divided into three domains: The *real*, the *actual*, and the *empirical*. The *real* deals with objects and structures which may result in invisible mechanisms. The *actual* is a subset of the real domain and deals with events that come from exercised and unexercised mechanisms (in the social world, it is the product of relationships expressed through language and day-to-day relationships). Finally, the *empirical* only deals with observable and experienced events (Bhaskar, 1978; Bhaskar, 2008). Structures and mechanisms (the real) produce ‘events’ (the actual) which can be observed and experienced differently (the empirical).

Table 3.1 shows the stratified ontology of critical realism. The domain of the *real* deals with structures, experiences, events, and mechanisms with enduring properties. The domain of the *actual* deals with events that are generated by the structures and mechanisms. And finally the domain of the *empirical* deals with the phenomena which are events that are observed and experienced.

	<i>Domain of Real</i>	<i>Domain of Actual</i>	<i>Domain of Empirical</i>
<i>Mechanisms</i>	✓		
<i>Events</i>	✓	✓	
<i>Experiences</i>	✓	✓	✓

Table 3.1. The stratified ontology of critical realism

Reproduced from Bhaskar, 2008:2

One of the approaches used to integrate qualitative and quantitative methods in order to hypothesize the generative mechanisms that cause events we are

experiencing is the retroductive approach which was focused on by Lawson (1997). Unlike deduction, which is the movement from general observations to specific conclusions, and unlike induction, which is the movement from specific observations to general conclusions, a different model of deduction was adopted by Lawson (1997) called “retroduction”:

It “consists in the movement, on the basis of analogy and metaphor, amongst other things, from a conception of some phenomenon of interest to a conception of some totally different type of thing, mechanism, structure that, at least in part, is responsible for the given phenomenon” (Lawson 1997: 24 cited in Downward & Mearman, 2002).

Figure 3.1 shows the retroductive approach of critical realism for knowledge creation and how it makes use of and combines the new knowledge from both quantitative and qualitative approaches with old knowledge.

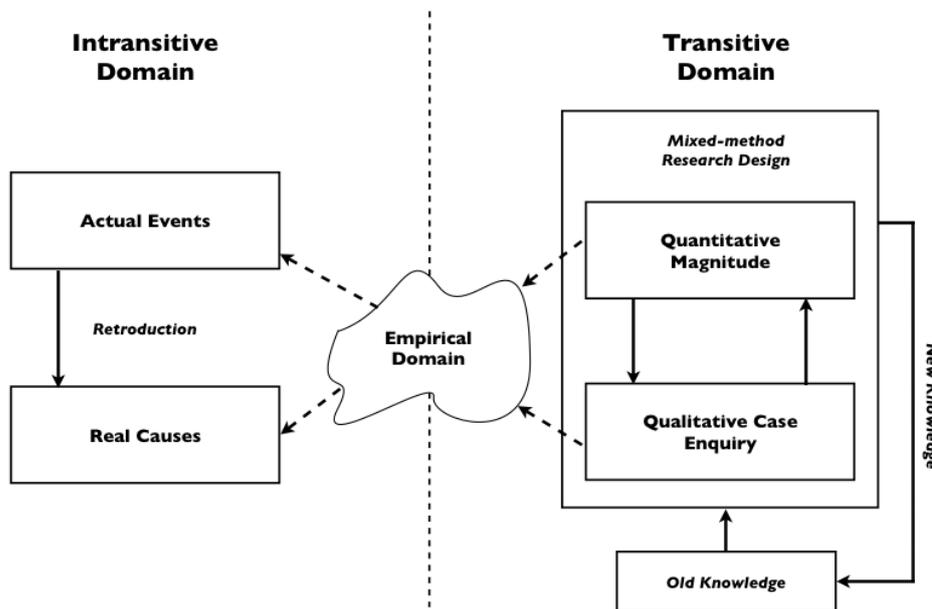


Figure 3.1. The retroductive approach of critical realism for knowledge creation

Reproduced from Zachariadis et al., 2011:859

In this figure, there is a separation between two domains, the transitive and the intransitive. The intransitive domain, shown on the left-hand side, describes structured reality in which real events are triggered by real causes through the retroduction of the causes. On the other side is the transitive

domain constituting of the overall knowledge, divided into old knowledge and new triangulated knowledge from both quantitative and qualitative methods. The dotted vertical line in the middle of the diagram constituting the empirical domain indicates the imperfect and partial correspondence of knowledge with reality under examination (Downward and Mearman (2007)). In this study's case, old knowledge represents the previous research on corporate governance. The quantitative and qualitative methods used in this study are triangulated as part of the transitive domain. The survey data gives a chance to understand the quantitative magnitude, allowing us to put rich insight we got from the interviews into perspective. This way we were able to draw conclusions about the experiences people report and what appears to be happening within the corporate governance of the studied hospitals.

As critical realism is frequently used in social sciences for mixed methods, Venkatesh et al. (2013) outlined three distinct categories of validity that are commonly used for both quantitative and qualitative research. These categories are the *design validity*, *measurement validity* (analytical validity), and *inferential validity* (Zachariadis et al., 2011). Since this study will be using critical realism instead of the conventional quantitative and qualitative research, the three types of validity outlined by Venkatesh et al. (2013) will be interpreted from critical realism point of view. In the quantitative research for example, actual events are viewed as expressions of the particular generative mechanism instead of being in a cause-effect form. Moreover, similar or related events that occur in different settings are considered to be caused by the generative mechanism that caused the actual events. Findings from statistics can provide information about the relationships of events observed in the empirical domain, but not the causal mechanisms that underpin them. On the other hand, in the qualitative research, the retroductive approach explained earlier is used for the analysis. Furthermore, findings from qualitative research are considered to provide information about the mechanisms that cause the events at the empirical level.

Many critical realists consider triangulation in their studies. Mixed methods triangulation can be perceived as the aspect of retroduction adopted by

critical realism (Downward & Mearman, 2007). As described by Fielding and Fielding (2008), *triangulation* is

“an epistemological claim concerning what more can be known about a phenomenon when the findings from the data generated by two or more methods are brought together” (Moran-Ellis *et al*, 2006: 47).

The term triangulation was first described by Donald Campbell in 1953 and 1959 (Campbell & Fiske, 1959). It is sometimes problematically used to substitute for the terms *intergration*, *combination*, and *mixing* of methods during a research.

A number of authors like Bryman (2004), Greene *et al.* (2001), and Kelle (2001) have studied the concept of triangulation. Many supporters of triangulation argue that triangulating methods aid in revealing distinct dimensions of phenomena and in understanding the multifaceted nature of the social world from theoretically driven bases. Greene *et al.* (1989) for example described triangulation as a process in which mixed methods are used to measure the same conceptual phenomenon within an empirical example. They differentiated it from complementarity in which mixed methods are used to assess overlapping but different features of a phenomenon (Greene *et al.*, 1989).

In the research strategy adopted here, the research will draw upon critical realism as a means of studying the overall governance at the selected hospitals. It will also employ retroduction and triangulation to the results in order to join both the quantitative and qualitative result interpretations into a realistic analysis. In the next section, the research will demonstrate how these theoretical and methodological concepts inform the research design.

3.1.2 Mixed Methods Research

Mixed methods studies may include both quantitative and qualitative approaches, or a mix of different qualitative data including positivistic, phenomenological, visual, and interpretive; according to Moran-Ellis *et al*, (2006), “qualitative research can in fact be positivistic” (Moran-Ellis *et al*, 2006 :56). Nowadays, mixed methods is increasingly being used, especially in sociologically-related problems and social intervention programmes (Greene *et al.*, 2001 in Moran-Ellis *et al*, 2006).

Among the benefits of mixed methods are the increase in the accuracy of both the research findings and the level of confidence, the generation of new knowledge by an interpretation of findings from different approaches, and the reflection of the complexity and ontology of phenomena (Moran-Ellis et al, 2006). Therefore, the use of mixed methods is considered to be a valuable research strategy.

Kelle (2001) states that the use of one method to study phenomena that operate both on micro and macro sociological levels is not enough for sociological explanation. He also states that in social research terms, the accurate explanation of a position requires at least two methods for measurement: one macro-level and one micro-level measurement (Kelle, 2001).

According to Greene et al. (1989), three uses of multiple methods do not involve the use of triangulation. The first one is the use of one method to inform the design of the other. The second is the use of the second method to increase the depth or breadth of the data generated by the first one. Finally, the third one is the use of mixed methods to encompass multiple components in a single empirical project (Greene et al., 1989).

To integrate is to 'combine (one thing) with another to form a whole' (Oxford dictionaries, 2015). This whole is not independent from the constituents combined, and does not omit its basic entities. Integration of methods is the use of two or more methods in order to form a greater knowledge of a research topic, while retaining the nature of each method. "Data integration is a crucial element in mixed methods analysis and conceptualization" (Fielding, 2012). Some integrations take place at later stages of the research process; for example in the analysis, interpretation, or in theorizing.

"Integration involves the generation of tangible relationships among methods, data and/or perspectives, retaining the integrity of each, through a set of actions clearly specified by the research team, and that allows them to 'know more' about their research topic" (Moran-Ellis et al, 2006 :51).

Equal weights must be given to the different methods in order for the process to be considered as an integration. Methods should also be oriented to common goals and research questions.

Integration may be achieved at different levels of the research process. Many mixed methods projects postpone integration to the phase of analysis or theoretical interpretation, although, according to Moran-Ellis *et al* (2006), the term 'integrated methods' is reserved for studies in which integration occurs from the starting point of conceptualization of the project and across all the phases of the research (Moran-Ellis *et al*, 2006). The first approaches to integration stated above may be through an integrated analysis, in which a diverse set of data and a common analysis are generated. The integrated analysis is done by retaining the characteristics of each type of data, and giving equal weight to their contribution to the analysis. An example of this case stated in Bazeley (2002) would be through using a common data analysis program like N-vivo in which both quantitative and qualitative data are transformed into numerical data which will be analysed through the same program. The second approach may be through a theoretical integration, sometimes referred to as 'interpretive integration' in which each data type is analysed within the parameters of its own paradigm and meet at the point of interpretation and explanation. Here, there is no combination of methods or analysis, but all sets of findings are brought together into a common explanatory framework.

When using mixed methods, methods may be taken as equal and this is called integration, they may influence the operationalization of each other, or they may be conducted simultaneously or sequentially (Punch, 2013). Whenever one method follows the other and does not contribute equally to the research, the process is described as *combination* of methods rather than integration. It is said that methods are *combined* (Clarke, 2003).

In this study, a mixed methods approach to data collection was implemented in order to answer the research questions adequately. A critical realist social research approach was used to inform the use of both quantitative and qualitative methods of data collection. As Johnson and Onwuegbuzie (2004) stated in their article on mixed methods research, in order to properly construct a mixed methods design, the researcher must make two key decisions: the first is whether he will be focusing on one paradigm and making it dominant over the other. The second is whether the researcher is

willing to conduct the phases concurrently or sequentially (Johnson and Onwuegbuzie, 2004). In this research, the results from the quantitative methods of data collection informed the strategy for qualitative data collection. The phases in this research were hence conducted sequentially; the quantitative approach followed by the qualitative. Therefore, this research uses an integration of methods, through using sequential collection of data, employing triangulation, and retrodution to produce a critical realist account of acutal events and real causes.

As previously stated in the literature review chapter, there is a clear lack of empirical work done on the corporate governance in Lebanese hospitals. This research study aims to bridge this gap through studying the hospital governance in Lebanon. The two most common theories of corporate governance explained in the literature review chapter are agency theory and stakeholder theory. Agency theory focuses on a limited set of relationships and understands the organisation as a closed system, while stakeholder theory takes relationships more into account and takes an external view for the corporation. The usefulness of these two major theories may not be easily reflected when dealt with on individual terms during the processes of both the quantitative and qualitative researches, as not all participants are aware of all the relevant relationships that are covered in the corporate governance theories. Participants may think about corporate governance differently according to their positions and their situations in the corporation. This is why critical realism makes the best choice for this study, as it can validate both the quantitative and qualitative results, based on 'actual events'. These actual events will be checked for their correlations to 'real causes' through the triangulation of qualitative and quantitative data. These actual events that are easy for participants to recognize are highlighted clearly in the questionnaires and interview questions used in this study.

3.2 Ethics and governance of the research project

As part of the official stages of the research degree regulations at the University of Brighton, and as described in the *University of Brighton Code of Practice and Regulations for Research Degrees, 2014/15*, I applied to the

University Research Ethics and Governance Committee with the required documents that were studied by this committee based on the key ethical standards set by the University. The major documents presented to the committee were: a coversheet including a general description of the research, an abstract, a governance checklist, letter used to access hospitals, letter used to request interviews, participant consent form for interviews, participant information sheet for interviews, participant information sheet for surveys, research plan, research tools (interview agendas and questionnaires), and a risk assessment form.

The process for the ethical approval of this research project was done through several stages.

First, I applied by sending the above stated documents to the online official system of the University Research Ethics and Governance Committee. Then two lists of comments were received from the committee and were clarified from my side, after being discussed with my supervisors (See full list of comments and replies in appendix).

On the 6th of May, 2015 an email from the University Research Ethics and Governance Committee was received stating that the research application has been approved by the Health and Social Science, Science and Engineering Research Ethics and Governance Committee. This was followed by the University of Brighton Public Liability insurance cover for the research. Hence, permission was granted and the research was able to proceed in regular communication with the supervisors.

3.3 Research design

A literature review was conducted at the beginning, searching for the published literature that is directly and indirectly related to corporate governance in Lebanese hospitals. Based on this review, the survey instruments were prepared and interview schedules were drafted to reflect the core research theories and concepts of interest and research questions. Fieldwork took place in Lebanon at three non-profit private hospitals within the Mount Lebanon region which is one of the biggest regions of Lebanon. It is also the largest province in terms of population size, the largest number of

hospitals, and largest percentage of non-profit hospitals. The research fieldwork began with negotiating access and ensuring ethical and research governance requirements were satisfied at the local level.

There were two stages to the research design. The first stage involved the development and distribution of a questionnaire, and the analysis of the data collected. The second stage built upon the first by taking findings from the quantitative analysis and using these to further develop the draft interview schedule. Data from the interviews was collected and analysed using techniques of thematic analysis according to the theoretical framework identified above.

The project followed a mixed methods approach where quantitative and qualitative approaches to data collection and analysis were used. The quantitative approach means that formal, objective, and systematic processes were used in order to obtain data and information. The quantitative approach was utilized in order to highlight evidence of the individual hospitals' corporate governance concepts and structures and to report the experiences of board members, managers, shareholders, medical doctors, and nurses. This approach helped describe, compare data, and test relationships. This was done by testing statements containing key hospital governance concepts described in the literature first through a pilot of seven respondents, then with the research participants, and further by seeing the extent to which they agree with them or not.

3.3.1 Sampling strategy

Before developing the survey instruments, a specific sampling strategy was chosen. First, the convenience sample, as one of the most commonly used sampling procedures (Farrokhi and Mahmoudi-Hamidabad, 2012), was used for the selection of hospitals to be studied, out of all the potential hospitals in Lebanon. Then, a census of all clinicians, managers, board members, and owners/shareholders working in the chosen hospital was attempted through dividing the population into five major groups (strata): owners/shareholders, managers (including CEOs, clinical managers, and non-clinical managers), board members, physicians, and licensed nurses. After that, a census of the major groups was used by inviting all staff of a certain grade to take part;

aiming to get the largest amounts of responses possible, representing the population. The census was also directly related to a convenience sample strategy, studied according to the availability and cooperation of all targets. The project also made use of a qualitative approach, which acted as a systematic approach to gaining deeper insight into the corporate governance issues identified in the findings of the quantitative analysis and to further answering the research questions. The qualitative approach was used to report a number of managers' point of views with respect to hospital performance and the incentivisation of managers. This data provided insight into how and why managers feel accountable to stakeholders including the owners/shareholders of the hospitals. It also provided an interpretation of their views and working experiences and how they thought improvements can be made. As for the sampling of interviewees, most senior managers in all three hospitals were invited to be interviewed. Some were contacted via a mediator that I was already in contact with since the beginning of the research, like the CEO and the president of one of the hospitals. Others were contacted through email, with detailed explanation of the purposes of the research, assuring confidentiality, and attaching the information sheet of the interviews. Selection was also based on convenience and availability of senior managers to be interviewed. Convenience sampling is known to constitute the most common form of qualitative sampling, where the researcher chooses the sample according to ease of access (Ritchie et al., 2013).

3.3.2 Choice of research site

Lebanon is divided into six provinces: Al-Nabatieh, Beirut, Bekaa, Mount Lebanon, North Lebanon, and South Lebanon. The total area of Lebanon is 10'452 square kilometres. The total Lebanese population as estimated by the Lebanese Ministry of Public Health in 2013 is approximately 4'167'769 inhabitants from which 1'547'096 are in Mount Lebanon (Ministry of Public Health, 2013). Mount Lebanon has the largest population among all other provinces, constituting 37% of the total Lebanese population (IGSPS, 2012). Mount Lebanon is also one of the largest provinces in Lebanon in terms of surface area (1968 square kilometres), constituting 19% of the total

Lebanese area (Ministry of Environment/LEDO, 2001). According to the most recent list of hospitals posted on the website of the Lebanese ministry of public health, Mount Lebanon is the province with the largest number of hospitals (51 hospitals), constituting 35% of the total number of hospitals in Lebanon (Ministry of Public Health, 2016). Moreover, Mount Lebanon has the largest percentage of non-profit private hospitals, making a total of 47% of all the Lebanese non-profit private hospitals.

The hospitals to be studied were chosen to be in Mount Lebanon as this province represents the health sector of the largest Lebanese population, and the largest amount of hospitals, especially non-profit private hospitals. From those hospitals, the sample of hospitals was chosen based on accessibility and convenience. Several hospitals were contacted and asked for their agreement to be accessed. Then the list was simplified into the ones who agreed. After that, three hospitals were chosen according to their fit with the research aims and design.

Figure 3.2 below shows the distribution of private and public hospitals contracting with the ministry of public health in the six Lebanese provinces, according to the latest lists of Lebanese hospitals published on the website of the Lebanese Ministry of Public Health in 2016. The total number of Lebanese hospitals according to the Lebanese ministry of public health is 146 (Ministry of Public Health- Lebanon, 2016).

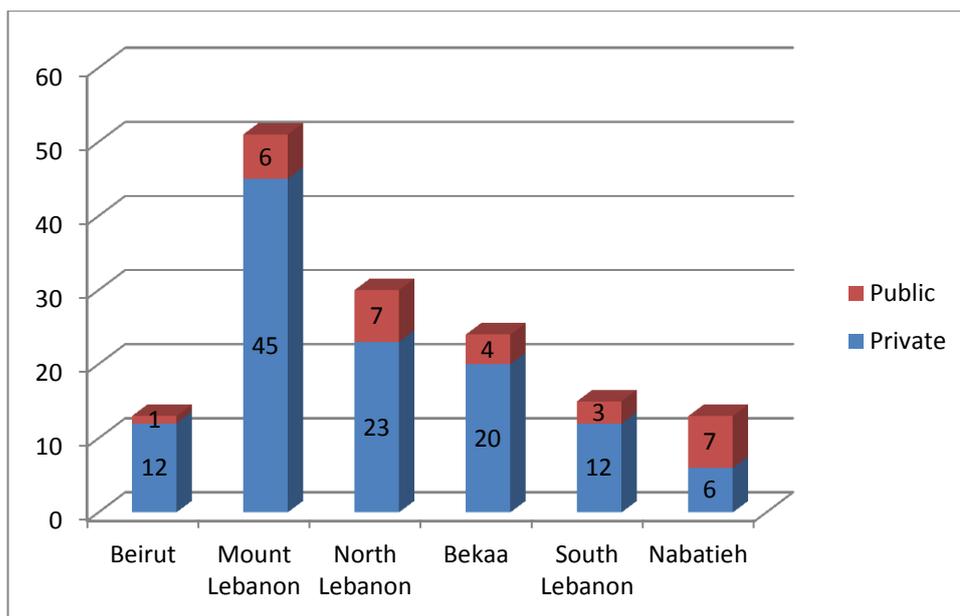


Figure 3.2. Hospitals contracting with ministry of public health by province and type (Ministry of Public Health, 2016)

Lebanon has 28 public (governmental) hospitals, and 118 private hospitals, making a total of 146 hospitals. These hospitals are divided into provinces as follows: Beirut has 12 private hospitals and 1 public hospital, Mount Lebanon has 45 private hospitals and 6 public hospitals, North Lebanon has 23 private hospitals and 7 public hospitals, Bekaa has 20 private hospitals and 4 public hospitals, South Lebanon has 12 private hospitals and 3 public hospitals, and Nabatieh has 6 private hospitals and 7 public hospitals.

Figure 3.3 shows the distribution of both for-profit and non-profit private hospitals contracting with the ministry of public health in the six Lebanese provinces, according to the latest lists of Lebanese hospitals published on the website of the Lebanese Ministry of Public Health in 2016, and to the list of private hospitals provided by the Syndicate of hospitals in Lebanon (2015).

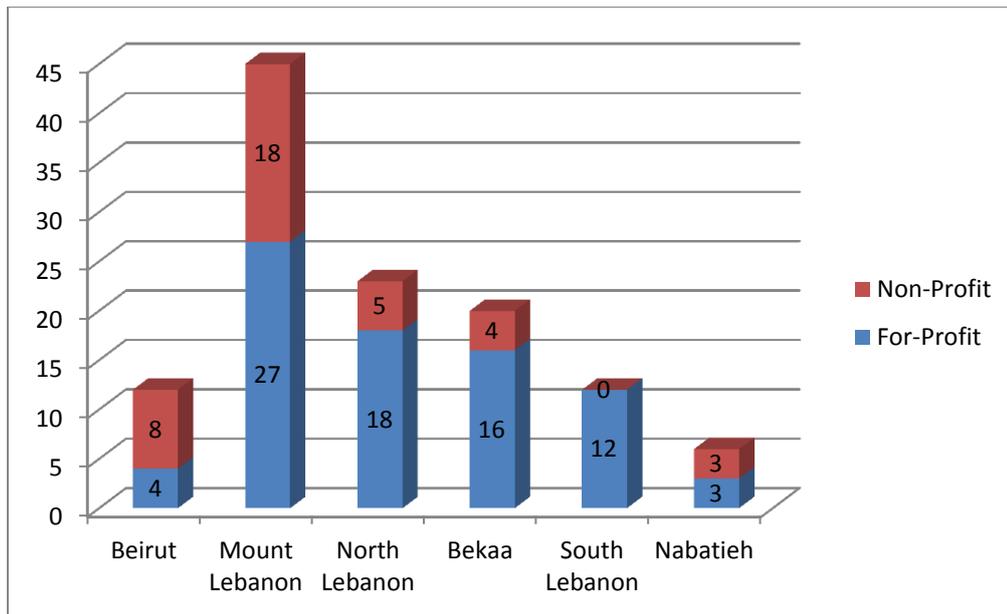


Figure 3.3. Private Lebanese Hospitals: For-Profit and Non-Profit hospitals by province and type (Ministry of Public Health, 2016 and Syndicate of hospitals in Lebanon, 2015)

According to the syndicate of hospitals in Lebanon, the total number of private non-profit hospitals is 38, and the total number of private for-profit hospitals is 80 (Syndicate of hospitals in Lebanon, 2015). These are distributed into provinces as follows: Beirut has 4 for-profit private hospitals and 8 non-profit private hospitals, Mount Lebanon has 27 for-profit private hospitals and 18 non-profit private hospitals, North Lebanon has 18 for-profit private hospitals and 5 non-profit private hospitals, Bekaa has 16 for-profit private hospitals and 4 non-profit private hospitals, South Lebanon has 12 for-profit private hospitals and no non-profit private hospitals, and Nabatieh has 3 for-profit private hospitals and 3 non-profit private hospitals.

The choice of non-profit private Lebanese hospitals in Mount Lebanon aims to reflect the hospital governance of this type of hospitals in Lebanon. Only 3 hospitals were chosen as a sample for the in-depth study of their governance systems and mechanisms, based on a convenience strategy to getting the right sort of hospitals, instead of using a random or quota sample approach that would make choosing a small number of hospitals impossible. Selection of hospitals was made on the basis of reasonable access and not for profit is

a key sub section and presented the best opportunities for access and openness of response.

In their study on corporate governance and corporate social responsibility in the Lebanese healthcare sector in 2010, Jamali *et al* (2010) divided the Lebanese hospitals into three categories: private for-profit hospitals; private non-profit hospitals which were all a part of a missionary or religious organisation; and governmental hospitals. They also demonstrated that in 86 per cent of the studied cases, the private for-profit hospitals were dominated by family owned hospitals. Among these private for-profit hospitals, the CEO was a family member in 43 per cent of the cases, or as the founder in 36 per cent of the cases, and in all cases, the CEO was also a major shareholder. In 71 per cent of the cases, the CEO was also the board chairman. On the other hand, all studied non-profit hospitals had the CEO as a manager who is not related to the founder (Jamali et al., 2010).

Ownership in family-owned hospitals was usually limited to a few family members, so corporate governance in this case is not really relevant due to the lack of minority shareholders, while the non-profit hospitals had all of its board members as independent board members. It was also demonstrated in Jamali's study that in several incidents in the for-profit, family-owned hospitals, the CEO/major shareholder filled out his own evaluation, due to the fact that the hierarchy is controlled by the family members themselves because of the lack of diffuse shareholders and because ownership was limited to few family members. Moreover, non-profit hospitals also showed a better consideration towards external stakeholders (Jamali et al., 2010).

Therefore, this research study will be targeting the non-profit private hospitals, which are all a part of a missionary or religious organisation, and constituting 26 per cent of the total number of Lebanese hospitals. This would be the best choice in this case as this category has the constituents of reasonable hospital governance.

As levels of corruption are relevant to corporate governance, next is a description of the overall level of corruption in Lebanon. Transparency International e.V. is an international non-governmental organization based in Berlin, Germany, founded in 1993. Since 1996 Transparency International

has published the Corruption Perceptions Index (CPI) annually. The CPI ranks countries "by their levels of corruption, as determined by expert assessments and opinion surveys." The organization generally defines corruption as "the misuse of public power for private benefit" (<http://www.nationsonline.org/oneworld/corruption.htm>).

Lebanon scored 28 points out of 100 on the 2016 Corruption Perceptions Index reported by Transparency International. Corruption Index in Lebanon averaged 28.57 Points from 2003 until 2016, reaching an all-time high of 36 Points in 2006 and a record low of 25 Points in 2009. Figure 3.4 shows the Lebanese corruption index on a scale from 100 (very clean) to 0 (highly corrupt), from 2006 to 2016 (<https://tradingeconomics.com/lebanon/corruption-index>).



Figure 3.4. Lebanon corruption index from 2006 to 2016

Lebanon is the 136 least corrupt nation out of 175 countries, according to the 2016 Corruption Perceptions Index reported by Transparency International. Corruption Rank in Lebanon averaged 111.64 from 2003 until 2016, reaching an all-time high of 136 in 2014 and a record low of 63 in 2006. Figure 3.5 shows the Lebanese corruption rank out of 175 countries, from 2006 to 2016 (<https://tradingeconomics.com/lebanon/corruption-rank>).



Figure 3.5. Lebanon corruption rank from 2006 to 2016

3.3.3 Choice of method(s)

As stated previously in this chapter, a mixed methods approach was implemented in order to answer the research questions. A critical realism research approach was used through the use of both quantitative and qualitative methods of data collection. The phases in the research were, conducted sequentially; the quantitative approach, followed by the qualitative approach, employing triangulation, and retrodution to produce a critical realist account of acutal events and real causes.

3.3.4 Data collection

Data collection focused on board members, managers and clinicians. The non-profit private hospitals this study is targeting have a general council acting as owners or shareholders. When the general council is referred to in the questionnaire, it means owners or shareholders of those specific hospitals.

The quantitative data collection focused primarily on clinicians (medical doctors and nurses), and secondarily on board members and managers. In the qualitative, in-depth data collection, the population studied mainly focused on managers. Hence, clinicians were excluded from the qualitative data collection stage. Managers are separated into different categories: general managers, clinical managers, and non-clinical managers. The

primary goal of the quantitative data was to provide information that precedes the preparation of the qualitative in-depth interviews targeting managers.

Therefore, table 3.2 shows the basis of the instrumentation for the data collection tools:

Data collection tools	Targets
	Managers
	Physicians
	Licensed nurses
	Board members
Semi-structured interviews	Managers
Relevant organisational documents	

Table 3.2. Instrumentation for the data collection tools

In order to obtain access to the hospitals, the owners and/or managers were contacted through some connections that I already have in Lebanon. First, the reason for the request was explained to the contacts in order to see if they would introduce me to the owners or managers of the hospitals. Then further explanation was provided to the owners/managers. My explanation was mainly that I am a PhD student at the University of Brighton and that my goal is to study those specific hospitals as a sample of the private sector of Lebanese hospitals. The goal of providing knowledge on how to improve the governance inside those hospitals was also stated. Confidentiality concerning keeping the names of the hospitals and sensitive data confidential was assured. An incentive was also given by promising them that they will be provided with this study's findings and suggestions for the improvement of the governance of their hospitals at the end of my research. In order to be able to estimate the population size, the management of the hospitals was asked to provide me with an official number of clinicians, owners/shareholders, and managers. The population was considered in

terms of role/job regardless of which hospital an employee contracts with. For example, medical manager of hospital X was studied as being a medical manager, irrespective of the hospitals he works at. The population was also considered in terms of role/job, taking into consideration which hospital an employee contracts with. For example human resources manager of hospital Z is described as being a member of hospital Z with his answers representing the situation at that hospital. Figure 3.6 shows a visual description of such analysis.

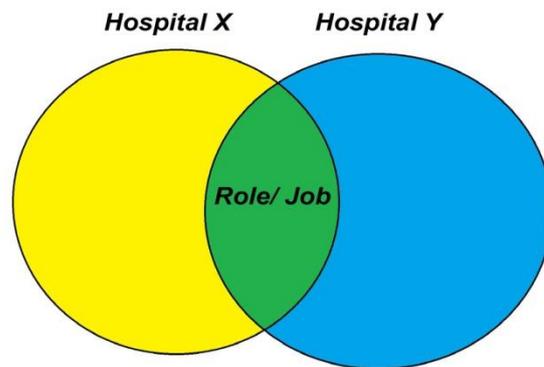


Figure 3.6. Job in each hospital versus job in hospitals in general

Therefore, an approach that includes a census of staff with certain jobs in the same hospital was followed. The questionnaire was attempted to be delivered as a census to all the clinicians, board members, owners/shareholders, and managers in each hospital, aiming to obtain the most significant results. The expected response rate was between 30% and 40%. As soon as the official list showing the distribution of the hospitals' staff was received, more specific details about the population were known, thus, an understanding of whether the response sample was to be representative or not.

3.4 Quantitative data collection

Surveys were collected via two methods: online surveys and paper-based surveys. First, clinicians (physicians and licensed nurses), board members, and managers were sent emails with a copy of the information sheet and two links to the survey: a link to the English version and another to the Arabic version. Then two follow-up emails were sent. After getting the maximum

amount of questionnaires completed online, the second method was followed: paper copies were distributed. English and Arabic versions of paper copies were administered to clinicians, board members, and managers who have not filled the online survey. An information sheet was also attached to the paper copies. The aim was to try to get them filled and collected back through collection boxes that were placed at different areas of the hospitals. Another aim was to collect the filled questionnaires during the same day in order to prevent biases. Biases in such cases may include: the questionnaire being taken back home and discussed with other people before being filled in; the loss of the paper based survey; and the risk that the respondents ask a family member or another person to fill the survey on their behalf.

The questionnaire was distributed to a total population of approximately 582 participants, divided into 3 hospitals as follows: 377 physicians, 185 licensed nurses, 15 clinical and non-clinical senior managers, and 5 members of the boards of directors. Out of this population, some participants may have had 2 or 3 roles at the same time (ex. physician and clinical manager), thus, the total number of participants may be slightly smaller than 582. The result was 207 completed questionnaires. The questionnaire was sent to everyone in the research population. Given that the research population did not include all hospital managers and all clinicians in Lebanon, it is important to be cautious when generalizing results from the response sample in this population to managerial and clinical issues outside of the targeted hospitals.

Qualitative interviews were used to explore the themes identified from the questionnaire analysis. Qualitative interviews gave more depth of information about how individual managers perceived governance issues in their hospitals.

3.4.1 Questionnaire design

At the top of the questionnaire was a diagram showing the shape of the hierarchy in the hospital.

The questionnaire began with some clarifying notes, followed by contextual demographic questions mainly focusing on age, gender, managerial role, managerial experience, leadership role, management education, current role

at the hospital, and number of years at the hospital. Then the detailed questionnaire was based on the research questions.

The questionnaire type of survey offered the quantitative approach. It was in the form of statements with multiple choice answers with the following five point Likert scale options:

- 1) Strongly agree
- 2) Agree
- 3) Neither agree nor disagree
- 4) Disagree
- 5) Strongly disagree

The respondents were offered the choice of answering "Neither agree nor disagree" whenever they did not know the answer, or did not have an opinion about the statement, perhaps because it was outside their knowledge or working experience. Moreover, all questions were required to be answered.

The use of Likert scale in questionnaires has been associated with making relative and absolute judgments about measures of attitude. There has always been a debate on the best structure of Likert scales. Many debates have been recorded on the number of points to be used, on whether there should be a middle or neutral point, and on the best form of response options (Leung, 2011). Two directions are often used in Likert scale as response options: horizontal and vertical. These directions are used for both descending (strongly agree to strongly disagree) and ascending (strongly disagree to strongly agree) order. Hence, four unidirectional response options can be used. These are the horizontal descending, horizontal ascending, vertical descending, and vertical ascending options. In addition to these four options, there are bidirectional responses and a random mix of descending and ascending responses (Maeda, 2015).

Figure 3.7 shows the four major unidirectional response options in Likert scale stated above.

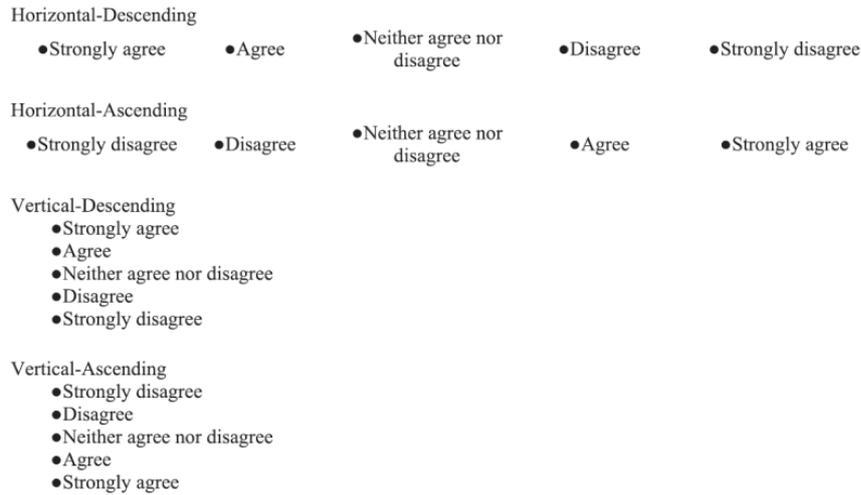


Figure 3.7. The four major unidirectional response options in Likert scale

Reproduced from Maeda, 2015:16

A study done by Nicholls et al. (2006) proved that it is more likely for respondents to select the response option located on the left than other available options ($\eta^2 = 0.015$), a case described as *hand preference*.

As shown previously, I will be using the vertical descending Likert scale answering options as the vertical option eliminates the tendency of hand preference selection bias since all options will be above each other, with none of them being more to left or right than the other. Moreover, the study of the effect of spatial biases on responses to Likert scales proved that an overall satisfaction was higher for the descending scale than for that of the ascending scale (Nicholls et al., 2006).

The statements were designed to reflect aspects of hospital governance, as indicated in the thesis research questions, making use of the performed literature review. The literature review helped in structuring the questionnaire statements as it gave coverage of the basic constituents of the concept of hospital governance. Since the concept of 'corporate governance' was expected not to be clearly understood by many of the respondents to the questionnaires, the concept was indirectly studied through studying its basic constituents in order to prevent biases from misunderstanding the terminology. The questionnaire was written using terms that can be clearly

translated into the Arabic language without losing any of their meaning, and without being misinterpreted. Since Lebanon is an Arab country and its primary language is Arabic, each respondent had the chance to choose one out of two versions of the questionnaire to fill: English or Arabic based on his/her preference. The information sheet was also presented in both languages.

Different questionnaires were prepared for different hospitals. The questionnaires included the same question ranking of statements, but the difference was in the diagram of hierarchy at the top of the questionnaire, which differed across different hospitals.

The questionnaire was designed in a way to cover all of the five research questions of this study, which by themselves cover the major concepts of corporate governance, specifically hospital governance. The research questions were the following: What is the nature of the agency problem in hospital governance? How and to what extent does governance vary between hospitals? What are the key measures of hospital performance? In what ways are managers and clinicians incentivised? And how and to what extent do external factors influence internal hospital governance?

The structure that was used for the questionnaire design is a systematic structure of the statements covering the research questions and different major concepts of corporate governance explored in the literature review at the same time (see table 3.3 below for a full list of how research questions and key concepts link to questionnaire statements. A full copy of the questionnaire is in the appendix).

	Research Questions + Key Concepts of Hospital Governance	Statement(s) number
Research Questions	What is the nature of the agency problem in hospital governance?	16, 34, 35, 36, 37, 38
	How and to what extent does governance vary between hospitals?	**
	What are the key measures of hospital performance?	14, 18, 20, 26, 29, 31
	In what ways are managers and clinicians incentivised?	14, 16, 32
	How and to what extent do external factors influence internal hospital governance?	22, 23, 24, 30
Key Concepts of Hospital Governance	Responsibility	12, 16, 25
	Accountability	38
	CEO Power	36
	Board's/Owners' power	35
	Relationship of Clinicians and Management	19
	Relationship of CEO and Board/Owners	34
	Incentivisation and remuneration	14, 16, 32
	Performance	14, 18, 20, 26, 29, 31
	Financial performance	11, 13, 21, 27
	Communication	28, 29
	Knowledge	39, 40
	Conflict of interest (agency theory/agency problem)	37
	Audit	15
	Control	10, 17, 33
	Stakeholders (stakeholder theory)	22, 23, 24
Quality and safety (clinical governance)	12, 14, 22, 29	

Table 3.3. Full list of how research questions and key concepts link to questionnaire statements

** Concerning the second research question (How and to what extent does governance vary between hospitals?), all ranked statements will potentially

reveal different cluster sets in response patterns, and this is potentially according to the hospital where the respondent is primarily employed. This question is analytical in nature because in order to answer it, a comparison has to be constructed between responses received from each hospital. This will be carried out as a part of a quantitative and qualitative analysis respectively. So this question was answered from the analysis, after seeing what differences there were between the different hospital responses.

3.4.2 Ethics and governance of the questionnaires

Before beginning the data collection, the general managers of the studied hospitals agreed to send from their personal email addresses the survey invitation email to the medical managers and the nursing care department managers and asked them to send it to the corresponding respondents in their departments. This aims to reassure the respondents that this project has been approved and to insist on its effect on the healthcare sector in general and on the improvement of the hospital governance in those hospitals. This method of invitation for online surveys protects the confidentiality of both the hospitals and the respondents by indirectly reassuring that this research has been approved by the hospital management before being filled. Confidentiality was also reassured by an information sheet attached to the invitation email, describing the project as a whole, and reassuring confidentiality of the survey. This method of survey collection was in line with ethics agreements accepted via an ethics and governance application presented to the University of Brighton.

An information sheet was attached to an invitation circulation email which included two links to the questionnaire: a link for the English version and another for the Arabic version. Two follow up emails were sent to the same targets. After getting the maximum amount of online-filled questionnaires, paper copies were distributed. The targets (who have not completed an online questionnaire) were asked to fill them in and put them back in collection boxes which were distributed in different locations of the hospital. The information sheet was also attached to the paper-based questionnaires.

The questionnaire was anonymous and confidential. No personal information such as name and address were recorded. In case a respondent worked in more than one of the targeted hospitals, he/she was required to answer the questionnaire according to the hospital where he/she works most frequently, as stated in the notes at the top of the questionnaire.

There was a background information section at the beginning of the questionnaire including gender, age, scale of managerial role, scale of managerial experience, scale of leadership role, management education or training, current role, and duration of work sections; however, all the questions were designed in a way to keep the respondent anonymous. This guaranteed the hospital's staff confidentiality. Before undertaking the questionnaire collection, copies of this questionnaire were presented to the hospital governance authorities for their consideration and observations.

Every questionnaire had an information sheet attached to it. No personal identification was used in the data coding and analysis. In the online survey analysis, data was downloaded and saved into a password-protected personal computer. The responses of the paper copies of completed questionnaires were copied into a spreadsheet and saved into a password-protected personal computer. Paper copies were kept in a locked filing cabinet, in order to be destroyed at the end of the PhD. Hospital names are anonymous, and they are described as *Hospital X*, *Hospital Y*, and *Hospital Z*.

3.4.3 Piloting Questionnaires

After designing the first draft of the questionnaires, a piloting process was performed by presenting the prepared questionnaire to a small population. Then, the collected results were checked for relevance, choosing which questions were best to be used. After considering the pilot responses and observations about the questions, some of the questions were edited to improve their reliability and validity.

The pilot questionnaire was sent to seven respondents: 1 senior manager, 3 physicians, and 1 nurse, all working in hospitals at the United Kingdom; and 1 Chief Executive Officer of a Lebanese hospital, and 1 Professor of corporate governance at a Lebanese University. Because of the difference in

context between the United Kingdom and Lebanon, the pilot questionnaire sent to respondents at the United Kingdom was slightly different. The wording 'general council' (Lebanon), for example, was replaced by 'trust board' (UK). Two questions on pay settings were also deleted because in the United Kingdom, the salary levels in the public healthcare system are set by the government.

In responding to the results of the piloting, the comments raised by the respondents were summarized and some questions were changed and edited accordingly. This was after studying the comments in detail and after reflecting carefully with supervisors about whether there was a need to change or edit question and statement wording.

3.4.4 Analysis of quantitative data

The results collected from the surveys were coded as quantitative data. The chosen software for analysis, SPSS, requires numerical coding for maximum functionality. Descriptive analysis, correlations, factor analysis, and cluster analysis were the main methods of analysis used. The purpose of analysis was to discover the relationship between statements about governance issues and to explore possible similarities and groupings of opinion between different managers and clinicians. Data collected through online filled questionnaires and through paper-based filled questionnaires were transformed into a Microsoft Excel file in order to be used in SPSS.

3.5 Qualitative data collection

3.5.1 Semi structured Interviews

Semi structured interviews targeting managers took place at the hospitals. The interviews were tape recorded. There was also some additional note taking. Then, the information was transcribed on the same day after the interviews. The questions reflected the results obtained through the interpretation of the quantitative data collected formerly and aimed to collect more data on different concepts of corporate and clinical governance. The interviews aimed to get as much precise answers as possible.

The use of qualitative methodology in this research was to support and add to the quantitative methodology as mixed methods seek the following: mixed

methods aim to gain complementarity through obtaining different views of the same phenomena; they aim to overlap in order to draw a complete picture of a phenomenon; in sequential mixed methods (as for the case of this research study), questions of one method emerge from the results of the previously implemented method, or the results of one method suggests hypotheses or research questions to be tested in the following method; they aim to expand and further explain the results obtained in the previous method; they aim to enforce the credibility of results obtained through previously implemented methods; they enable the compensation of some of the weaknesses of a method by the use of the other; and finally, they aim to obtain divergent views of the same phenomena (Venkatesh et al., 2013).

3.5.2 Semi structured Interviews design

The interviews offered a qualitative approach of data collection. Interviews took the form of semi-structured interviews with pre-set questions that cover the concepts to be studied. The questions were designed to reflect aspects of hospital governance, as indicated in the thesis research questions. The concept of 'corporate governance' was indirectly studied in the interviews as in the questionnaire in order to prevent biases from misunderstanding the term 'corporate governance'. The questions were designed using terms that can be clearly and easily translated between English and Arabic languages without losing any of their meaning, and without being misinterpreted. Since Lebanon is an Arab country and its primary language is Arabic, each interviewee had the chance to choose to be interviewed either in Arabic or in English based on his/her preference.

The same set of questions was prepared for the different hospitals, with a possibility to modify some questions on the spot whenever necessary, as the interviews were semi-structured.

The interview strategy was such that interview questions were designed in a way to cover all the research questions. The questions were designed to cover all the basic concepts of corporate and clinical governance studied previously in the quantitative part and to check for the differences in perception of hospital governance at the hospitals. This interview strategy aimed to explore and clarify the views of the interviewees on the results

obtained through the quantitative data analysis and to further clarify their perceptions of corporate governance at the hospitals they work in, through discussions of their personal experiences in the hospitals. The interviews were designed in a way to link the conceptual framework from the literature review to quantitative statements, and to interview data.

The same research questions stated previously for the questionnaire were followed to design the interviews. Some examples of questions which were directly related to research questions were:

1- Examples of interview questions on research question 1 (What is the nature of the agency problem in hospital governance?):

What are the main tasks that you are involved in your day-to-day work at this hospital?

Who are you responsible for? And Who do you report to?

How would you describe the relationship between the management and clinicians?

Can you briefly describe the hierarchy in this hospital?

How is communication across the hierarchy of this hospital carried out?
(Visits, Other communications)

Who do you consider yourself accountable to?

Do you see that the senior management, board members, and general council have appropriate professional backgrounds and experience?

Can the CEO prioritize his/her personal interests over the interests of the hospital? What prevents them?

2- Examples of interview questions on research question 2 (How and to what extent does governance vary between hospitals?):

Can you briefly describe the hierarchy in this hospital?

How is communication across the hierarchy of this hospital carried out?
(Visits, Other communications)

Do you see that the senior management, board members, and general council have appropriate professional backgrounds and experience?

3- Examples of interview questions on research question 3 (**What are the key measures of hospital performance?**):

Would you describe this hospital as an efficient hospital? If No, how could it be improved?

In your opinion, do you see this hospital as being well-organized? If No, how could it be improved?

How is the overall performance of the hospital measured (internally) and judged (externally)?

Who is responsible for the financial performance at this hospital?

4- Examples of interview questions on research question 4 (**In what ways are managers and clinicians incentivised?**):

Are there good incentives for working at this hospital? What are they?

Are all staff personnel paid well in this hospital?

Are the incentives the same for all staff?

5- Examples of interview questions on research question 5 (**How and to what extent do external factors influence internal hospital governance?**):

Are all your tasks related to internal requirements? Or does some of them relate to requirements set by external organisations eg Order of Physicians, Ministry of Health, Syndicate of private hospitals, ...

How is the overall performance of the hospital measured (internally) and judged (externally)?

Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?) (Can you give an example?)

The same interview questions covered the following major concepts of corporate and clinical governance: Responsibility, accountability, power, CEO power, board's/owners' power, relationship of clinicians and management, relationship of CEO and the board/owners, incentivisation and remuneration, performance, financial performance, communication, knowledge, conflict of interest, audit, control, stakeholders, stakeholder

theory, agency theory and agency problem, and quality and safety (clinical governance).

A- Responsibility

What are the main tasks that you are involved in your day-to-day work at this hospital?

Who are you responsible for? And Who do you report to?

In your opinion, do you see this hospital as being well-organized? If No, how could it be improved?

We all know that errors occur at hospitals. Do you think that errors are dealt with well at this hospital?

In your opinion, who's responsible for patient care quality and safety?

Are (all) contracts at this hospital renewed according to performance?

Are all staff paid well in this hospital?

Are the incentives the same for all staff?

Can you briefly describe the hierarchy in this hospital?

Who is responsible for the financial performance at this hospital?

Do you see that the senior management, board members, and general council have appropriate professional backgrounds and experience?

B- Accountability

Are (all) contracts at this hospital renewed according to performance?

Who do you consider yourself accountable to?

C- CEO Power

Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?) (Can you give an example?)

Can the CEO prioritize his/her personal interests over the interests of the hospital? What prevents them?

D- Board's/Owners' power

Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?) (Can you give an example?)

Can the CEO prioritize his personal interests over the interests of the hospital? What prevents them?

E- Relationship of Clinicians and Management

Do you think people in this hospital are more focused on internal requirements than external requirements? (stakeholder approach)

Are the systems of reporting clear at this hospital? (Clinical Vs Management reporting)

Are there any problems with reporting?

How would you describe the relationship between the management and clinicians?

Can you briefly describe the hierarchy in this hospital?

How is communication across the hierarchy of this hospital carried out? (Visits, Other communications)

Is there a shared strategic vision for this hospital? Is it shared by all staff?

F- Relationship of CEO and Board/Owners

Are the systems of reporting clear at this hospital? (Clinical Vs Management reporting)

Are there any problems with reporting?

Can you briefly describe the hierarchy in this hospital?

How is communication across the hierarchy of this hospital carried out? (Visits, Other communications)

Is there a shared strategic vision for this hospital? Is it shared by all staff?

G- Incentivisation and remuneration

Are there good incentives for working at this hospital? What are they?

Are all staff paid well in this hospital?

Are the incentives the same for all staff?

H- Performance

Would you describe this hospital as an efficient hospital? If No, how could it be improved?

In your opinion, do you see this hospital as being well-organized? If No, how could it be improved?

How is the overall performance of the hospital measured (internally) and judged (externally)?

Are (all) contracts at this hospital renewed according to performance?

Who is responsible for the financial performance at this hospital?

Can the CEO prioritize his/her personal interests over the interests of the hospital? What prevents them?

I- Financial performance

In your opinion, do you see this hospital as being well-organized? If No, how could it be improved?

How is the overall performance of the hospital measured (internally) and judged (externally)?

Are (all) contracts at this hospital renewed according to performance?

Who is responsible for the financial performance at this hospital?

Can the CEO prioritize his/her personal interests over the interests of the hospital? What prevents them?

J- Communication

Are the systems of reporting clear at this hospital? (Clinical Vs Management reporting)

Are there any problems with reporting?

How would you describe the relationship between the management and clinicians?

Can you briefly describe the hierarchy in this hospital?

How is communication across the hierarchy of this hospital carried out? (Visits, Other communications)

Is there a shared strategic vision for this hospital? Is it shared by all staff?

K- Knowledge

Are (all) contracts at this hospital renewed according to performance?

Is there a shared strategic vision for this hospital? Is it shared by all staff?

Do you see that the senior management, board members, and general council have appropriate professional backgrounds and experience?

L- Conflict of interest (agency theory/agency problem)

Is there a shared strategic vision for this hospital? Is it shared by all staff?
Can the CEO prioritize his/her personal interests over the interests of the hospital? What prevents them?

M- Audit

Are the systems of reporting clear at this hospital? (Clinical Vs Management reporting)

Are there any problems with reporting?

How is the overall performance of the hospital measured (internally) and judged (externally)?

Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?) (Can you give an example?)

N- Control

Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?) (Can you give an example?)

Who is responsible for the financial performance at this hospital?

Can the CEO prioritize his/her personal interests over the interests of the hospital? What prevents them?

O- Stakeholders (stakeholder theory)

Are all your tasks related to internal requirements? Or does some of them relate to requirements set by external organisations e.g. Order of Physicians, Ministry of Health, Syndicate of private hospitals, ...

Do you think people in this hospital are more focused on internal requirements than external requirements? (stakeholder approach)

Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?) (Can you give an example?)

P- Quality and safety (clinical governance)

In your opinion, do you see this hospital as being well-organized? If No, how could it be improved?

Would you describe this hospital as having a good standard of care? (quality and safety)

We all know that errors occur at hospitals. Do you think that errors are dealt with well at this hospital?

In your opinion, who's responsible for patient care quality and safety?

How is the overall performance of the hospital measured (internally) and judged (externally)?

3.5.3 Ethics and Governance of the semi structured interviews

The University of Brighton Research Ethics and Governance process was applied for before undertaking the interviews. The ethics and governance application gave account of how the risk to those taking part was to be managed, especially in regards to their anonymity and confidentiality, so there were no consequences for these participants. Before the interviews were done, interviewees were offered an information sheet informing them about the purposes, the aims, and important details of the research project, including their right to withdraw at any point and the degree to which their anonymity and confidentiality can be protected. It was made clear in the participant information sheet that there will be only one condition where confidentiality will be broken. This was when patient harm was discovered; past or intended, and that can or should have been avoided. It was the researcher's duty, then, to refer the person/people responsible for this harm to the relevant quality and safety manager of that hospital. Interviewees were also asked to sign the consent form before the beginning of the interviews. The consent form explains their duties and responsibilities during and after the interview. These two forms, the information sheet, and the consent form, ensure confidentiality of the study and clarify each of the roles of the researcher and the interviewee in the overall process. After that, the interviews proceeded.

Using staffing, where interviewees were chosen after a narrowed-down list of potential candidates, based on their managerial roles in the three different

hospitals, different senior managers in all three hospitals were selected and invited to be interviewed by receiving an email containing a full explanation of the voluntary nature of the research, the right to withdraw at any stage, the assured confidentiality in regards to future publication of results and the purpose of the research. Then, two follow up emails were sent for those who didn't respond. After that, a face to face follow up was performed, giving them an information sheet and inviting them again. Some other managers were contacted by phone after being introduced by the president of the hospital, or the CEO.

Those who agreed to take part had to sign a participant consent form before the interview. Then, a tape recorded face to face semi structured interview was performed with each of them. Recordings were transferred to a password-protected personal computer and transcribed. Transcripts were completely anonymous. Any personal identification information was removed. Pseudonyms like *Manager at hospital X* and *Manager at hospital Z* were used. Recordings were held until the end of the study in order to be destroyed. After interviews were completed, all the emails were deleted.

3.5.4 Access to semi structured interview participants

During the process of getting the acceptance to study the hospitals targeted, and while providing explanations about the type of study, the CEO was informed about my interest in interviewing senior managers later during the process of data collection. Then, during the first part of data collection (the surveys), the need for later semi structured interviews was advertised for in the hospitals. The maximum amounts of targets were invited to be interviewed, mainly based on the likelihood of a few volunteering.

3.5.5 Development of the interviews

Based on research questions and on findings from the quantitative data analysis of the surveys, the semi structured interview schedule was developed. Semi-structured, in-depth interviews were performed, as a semi-structured interview format is most frequently used in healthcare research to elicit details (Gill, 2008). These interviews targeted senior managers. An interview is the most widely used method among all other qualitative study

methods, as is the case of surveys for quantitative methods (Venkatesh et al., 2013).

Out of all the managers invited for interviews, 8 senior managers were interviewed. The main reasons that the others were not interviewed were primarily due to their busy schedules and their absence during the data collection period, mainly for professional purposes.

The interviews were tape recorded, and notes were taken. Then the information was transcribed on the same day after each interview. These interviews offered qualitative data, primarily covering the research questions of the research project and the main concepts of corporate and clinical governance. They also provided an interpretation of the views and working experiences and how interviewees thought improvements can be made. The main purpose of the interviews was to explore anomalies or complex reflections that would help answer the research questions.

Interviews began with more general and open-ended questions and then moved toward more detailed and precise ones where conceptual issues and opinions that had substantially emerged during the earlier quantitative research phase were checked.

Some of the interviewed senior managers were also medical doctors, and questions were asked about their view of their management acts (as they have managerial roles too). It was important to explore the opinions of those with both professional clinical roles and managerial roles.

Table 3.4 shows a spread of interview participants according to role and hospital where they work.

Hospital	Managers Interviewed
Hospital X	Medical Manager + Physician
	Human Resources Manager + Scientific Director + Physician
	Nursing Manager
Hospital Y	Medical Manager + Physician
	Executive Director
	Nursing Manager
Hospital Z	Medical Manager + Physician
	Human Resources Manager

Table 3.4. Interview participants according to role and hospital

3.5.6 Analysis of qualitative data

The data analysis performed for the interviews followed the inductive approach instead of the deductive approach. Whilst a deductive approach tests theories, an inductive approach is concerned with the generation of new theories emerging from the data, exploring new phenomena, or looking at previously researched phenomena from a different perspective. The inductive approach is usually based on research questions instead of hypotheses. For the analysis itself, the data was thematically coded, which is an approach to organizing and categorizing data to facilitate their analysis.

3.5.6.1 Thematic analysis

In the qualitative data analysis, thematic analysis was used as a method to interpret and analyse the data obtained through interviews. Themes were looked for interpretively in the transcribed interviews. Themes express shared characteristics, forming a pattern in the data obtained in the interviews. Those themes were directly related to the main concepts of corporate governance covered in the research questions of this study.

In their famous article on using thematic analysis in psychology, Braun and Clarke (2006) defined six phases for thematic analysis as follows:

The first phase is *familiarization with the data* through transcribing it. The second phase is *generating initial codes*. They suggest marking codes with different colours, while taking notes of each code with its corresponding colour. The third phase is *searching for themes*. This is done through combining codes into themes. The fourth phase is *reviewing themes* and checking if these themes can be further combined into different themes. The fifth phase is *defining and naming themes*. The already combined codes into themes are to be labeled in this step, based on their relations to the theoretical framework under study. The sixth and final phase is *producing the report*. This is the resulting phase where the connections and relations among themes and research questions are shown. This can be done either inductively through showing how the themes emerge from the data, or deductively through showing how the data making the themes is related to the research questions under study.

Braun and Clarke (2006) discussed clearly how proper thematic analysis is done. They divided it into different steps which must be implemented sequentially, and to which they advise to give equal importance. The first step is the *transcription* step. Here, the data should be transcribed properly with enough details and with the exact accuracy as tape recorded. The second step is the *coding*. In the coding step, equal attention must be given to all data items. Codes are generated, and then joined to form themes. Themes are then collated into more general themes which are consistent, coherent, and distinctive. The next step is the *analysis*. In this stage, interpretation of the data is performed. The data and the analysis should match and be consistent, making a detailed and analytical narration of the topic. The final step is *writing the report*, where clear explanation to thematic choices and thematic analysis is reported.

3.5.6.2 Coding

Coding is a process of organizing and sorting data. It summarizes the concepts residing in the data. After data collection and the basic interpretations, coding is the link to the development of the data analysis. In

order to do the coding and qualitative analysis properly, a storyline should be developed. Here, the purpose of the evaluation, being the storyline describing what the evaluation is about, is highlighted before, during, and after data collection.

In creating the storyline, the researcher should state what he/she is trying to find out, and what he wants to convey with the information collected through the data. The storyline helps in the decision of what concepts and themes are to be communicated in the analysis report; it helps in how the data will be organized and coded; and it draws the basic structure of the coding scheme. In order to prevent the lack of coherence of the coding scheme, the researcher should be able to identify clearly what he/she will end up writing in terms of reporting. Thinking about the purpose of the study before proceeding with it is very essential; a process called *end-use strategizing*.

There are several ways to code data. Each coding category must be assigned a word, phrase, number, symbol, or colour. Ideas, concepts, and themes should be studied systematically to fit the categories assigned. Creating codes can be pre-set or emergent. A mix of both of these models usually gives the best results. Before proceeding in coding the data, it is best to set a list of pre-set codes based on the research questions, and concepts to be studied. These are known as 'piori codes'. These pre-set codes can also be derived from prior knowledge and experience of the studied topic. It is best to reduce the number of codes as much as possible in order not to get confused and overwhelmed by the common concepts covered by the different pre-set codes. A list of these codes and their definitions and connotations should be clear and written in what is known as a 'code book'. When reading and analyzing the data, another set of codes appear. These are known as 'emergent codes'. These are based on concepts, actions, relationships, and meaning emerging from the data and different from the pre-set codes. A set of priori codes was specified for the interview transcripts of this research. Each code was assigned a colour. For example, 'corporate governance' was assigned a red colour; 'clinical governance' a yellow colour; 'corporate governance events' a grey colour; 'external stakeholders' a blue

colour, and 'perception of hospital governance' a pink colour (see appendix for a full example).

Coding can be seen as a method system of organizing data. It is also seen as a filing system with the code being the folder. Some questions are best to be questioned in order to code data properly. These are: What is the data saying? What does it represent? What does this example represent? What is going on? What is happening? What kinds of events are described? What information is being conveyed? Answers to the above questions can be summarized by symbols, concepts, numbers, actions, or meaning, making the codes. The most used types of codes are words or phrases, as numbers are symbols that can sometimes be confusing.

Coding is a basic part of thematic analysis. The old style of coding included *substantive coding* in which the coding was described as a first-order coding where the codes are closely related to the data. It also included *theoretical coding* in which coding was called as a second-order conceptualization of how the first order substantive codes relate to each other (Glaser and Strauss, 2009).

A newer style of coding currently used has three stages according to Strauss and Corbin (1990). The first stage is the *open coding* in which data is broken down in order to be conceptualized and categorized. The concepts are joined together through *axial* coding to form categories by linking the codes to contexts, patterns, and causes. The final stage known as the *selective coding* is "selecting the core category, systematically relating it to other categories, and filling in the categories that need further refinement and development" (Strauss and Corbin 1990: 116).

As for some technical methods for coding data, it is suggested to use coloured pens for transcribed data. This method works on all forms of text, where a specific number of colours should be used, each identifying a code or a concept, and thinking about themes to be identified. Then is the stage of reporting the data. In this stage, a description of what was found in the data should be presented; statements from the transcription which explain what was found should be stated. Identified codes should be reported. It should also include an explanation of how the themes were generated, through

illustrating what was said. The strength and importance of the data should also be discussed (Erickson, 2002). Two main types of thematic analysis are usually known. These are the deductive thematic analysis where the analysis starts with a general theory, then moves to observations, leading to inference or deduction. The second type is the inductive thematic analysis where it starts with a case, then moves into the observations about the case, leading to generalizations. Inductive thematic analysis looks for concepts emerging from the data.

Chapter 4

QUANTITATIVE ANALYSIS

4.1 Method of analysis

In this chapter, the quantitative data obtained from questionnaires is analysed. Descriptive analysis, correlations, and factor analysis were the main methods of analysis used. The primary purpose of analysis was to discover the relationship between item statements about perceptions of governance and to explore possible similarities and groupings of these items between different managers and clinicians. Data which was collected through questionnaires completed by respondents online and through paper-based filled questionnaires was transformed into a Microsoft Excel file and then copied into SPSS software, which was the chosen software for analysis.

Descriptive analysis shows general information about the distribution of data, the number of respondents for each question or statement (coded as variables), the minimum and maximum scores, the mean and standard deviation for each, and the skewness of the results. Correlations are measuring the strength of a linear association between two variables and are denoted by r .

Factor analysis is a data reduction technique. It takes a large set of variables that the researcher expects to be at least partly correlated and looks for ways in which data can be reduced or summarized using a smaller set of variables or components. It does this by looking for a single group, or several groups that have strong inter-correlations within a set of variables. What factor analysis and principal component analysis do is analyse the correlations or relationships between the variables, looking for the optimal sub set of variables which explain the correlations obtained between all the variables studied. The resulting factors can be referred to as 'dimensions', so if we have 1 factor, it is a 1 dimension solution; 2 factors is a 2 dimension solution, etc...

The researcher starts with a large number of individual statement items or questions, and then by using this analytic technique of factor analysis, these items are refined and reduced into a smaller number of subscales. Two

related techniques fall under the name of factor analysis. These are the principal component analysis technique (PCA) and the standard factor analysis (FA). These techniques have lots of similarities, trying to develop a small number of linear combinations within the original variables. They also vary in several different ways. Differences between PCA and FA are subject to quite a lot of highly technical debate in the literature (Thompson, 2004; Jolliffe, 2002). PCA checks for the variance in all the variables. In standard factor analysis, factors are estimated using a different mathematical model. The only variance analysed is the shared variance instead of the total variance.

If the researcher was interested in developing a theory in theoretical research or if he/she was looking for a theoretical solution; in other words, in a perfect world situation, standard factor analysis should be the choice. On the other hand, if the researcher was interested in a more practical application and wants an empirical real world reduction and summary of a data set, then principal component analysis should be the choice. This is the case of this study where data from the empirical real world are used to be analysed for practical results. It is also necessary to reduce all the statement item scores to the best principal component or common factor that summarizes the staff's perception of hospital governance. Principal component analysis is the most commonly used procedure for this type of research and is also the default procedure in SPSS software.

4.2 Analysis

First, a descriptive analysis was done in SPSS (table 4.1). This shows the results of the descriptive analysis for all questions (including demographic variables) and statement items. Table 4.2 shows that for the statement items measured with a five point ordinal scale where 1 = strongly agree and 5 = strongly disagree, the mean average score for the sample varies between 1.83 and 3.14 with the majority scoring close to 2.5. For all statement items, the standard deviation is never greater than 1.18 or less than 0.78.

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
DEMOGRAPHIC VARIABLES							
To what extent do you see yourself having a managerial role on a scale of 1-10 where 1 represents no management role?	207	1	10	5.68	2.450	-.485	.169
To what extent have you had management experience on a scale of 1-10 where 1 represents no management experience?	207	1	10	5.72	2.435	-.415	.169
To what extent do you see yourself having a leadership role on a scale of 1-10 where 1 represents no leadership role?	207	1	10	6.51	2.304	-.705	.169
Gender	207	1	2				
Age	207	1	4				
Have you had any management education or training?	207	1	3				
What is your current role at the hospital	207	2	8				
How long have you been working at this hospital	207	1	3				
Which hospital do you currently work in	207	1	3				

Table 4.1. Descriptive Statistics for demographic variables

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
STATEMENT ITEMS							
The hospital's General Council should have control over the activities of all hospital managers	207	1	5	1.94	.863	.937	.169
If a serious mistake is made with hospital financial accounting the General Council will hold the relevant manager responsible	207	1	5	2.33	.980	.677	.169
In this hospital all serious clinical errors are investigated appropriately	207	1	5	2.47	1.037	.520	.169
Not all hospital managers are responsible for the financial performance of this hospital	207	1	5	2.30	.939	.527	.169
The General Council ensures that clinicians (physicians and nurses) are well-paid in order to ensure efficiency and good care in this hospital	207	1	5	2.73	1.183	.458	.169
It is the responsibility of the General Council to ensure good independent financial audit of this hospital	207	1	5	2.18	.785	.514	.169
The Chief Executive Officer (CEO) of this hospital is well-paid for the level of responsibility he/she has	207	1	5	2.46	.786	-.286	.169
There should be more control over how the Chief Executive Officer (CEO) spends this hospital's money	207	1	5	2.30	.886	.080	.169
All hospital managers should have fixed-term employment contracts which are reviewed and renewed against their performance	207	1	5	1.83	.781	.809	.169
If clinicians (physicians and nurses) develop new clinical procedures that build their own professional status, these may be too risky and expensive for the hospital to support	207	1	5	2.84	1.153	.239	.169
It is difficult for hospital managers to prioritize patient safety and quality of patient care	207	1	5	3.14	1.112	-.238	.169
It is in the interests of the General Council to pay senior managers high salaries	207	1	5	2.66	.986	.170	.169
The Ministry of Public Health has too much influence on this hospital	207	1	5	2.53	.846	.531	.169
The Syndicate of Hospitals pays too much attention to achieving benefits for the owners of this hospital	207	1	5	2.62	.827	-.123	.169
The Lebanese Order of Physicians strongly represents the physicians' interests in this hospital	207	1	5	2.43	.878	.375	.169

Patients are able to rely on the law to hold clinicians (physicians and nurses) to account	207	1	5	2.39	.822	.767	.169
I would expect non-profit hospitals to be managed better than private, for-profit hospitals	207	1	5	2.61	1.050	.559	.169
It is important for non-profit hospitals to make a surplus of money that can be reinvested	207	1	5	2.26	.928	.829	.169
I would expect at least an occasional visit from a member of the General Council to my department	207	1	5	1.95	.829	1.227	.169
Clinical performance of this hospital is managed appropriately through clear reporting	207	1	5	2.46	.969	.747	.169
External factors like politics or the economic situation of the country have too much influence on what happens in this hospital	207	1	5	2.02	.916	.870	.169
This hospital is well-organized and efficient	207	1	5	2.65	1.059	.511	.169
All managers in this hospital are rewarded adequately for their work	207	1	5	2.78	.864	.264	.169
The General Council does not have enough control over the pay rises of managers	207	1	5	2.88	.990	.124	.169
I am confident that the General Council and the Chief Executive Officer (CEO) have a shared strategic vision for this hospital	207	1	5	2.38	.849	.295	.169
The General Council has the power to direct the Chief Executive Officer (CEO) to act in exceptional circumstances if they see it is for the hospital's benefit	207	1	5	2.28	.835	.442	.169
The Chief Executive Officer (CEO) in this hospital has more power than the General Council	207	1	5	2.94	1.057	-.048	.169
The Chief Executive Officer (CEO) cannot prioritize his/her personal interests over those of the hospital	207	1	5	2.21	.894	.638	.169
The main objective of the Chief Executive Officer (CEO) is to ensure the hospital makes a surplus of money	207	1	5	2.49	.980	.505	.169
The Chief Executive Officer (CEO) has an appropriate professional background	207	1	5	2.38	.894	.459	.169
The members of the General Council have appropriate professional backgrounds	207	1	5	2.58	.909	.490	.169
Valid N (listwise)	207						

Table 4.2. Descriptive Statistics for statements

Tables 4.3 to 4.11 below show the frequencies for the demographic distribution of respondents:

To what extent do you see yourself having a managerial role on a scale of 1-10 where 1 represents no management role?

Score	Frequency	Percent
1	24	11.6
2	6	2.9
3	8	3.9
4	13	6.3
5	39	18.8
6	33	15.9
7	28	13.5
8	35	16.9
9	15	7.2
10	6	2.9
Total	207	100.0

Table 4.3. Frequencies for managerial role

To what extent have you had management experience on a scale of 1-10 where 1 represents no management experience?

Score	Frequency	Percent
1	20	9.7
2	7	3.4
3	12	5.8
4	15	7.2
5	38	18.4
6	28	13.5
7	28	13.5
8	39	18.8
9	12	5.8
10	8	3.9
Total	207	100.0

Table 4.4. Frequencies for management experience

To what extent do you see yourself having a leadership role on a scale of 1-10 where 1 represents no leadership role?

Score	Frequency	Percent
1	9	4.3
2	6	2.9
3	11	5.3
4	12	5.8
5	28	13.5
6	18	8.7
7	36	17.4
8	49	23.7
9	27	13.0
10	11	5.3
Total	207	100.0

Table 4.5. Frequencies for leadership role

Gender

	Frequency	Percent
Male	87	42.0
Female	120	58.0
Total	207	100.0

Table 4.6. Frequencies for gender groups

Age

Range	Frequency	Percent
18-25	11	5.3
26-35	65	31.4
36-50	94	45.4
51 and above	37	17.9
Total	207	100.0

Table 4.7. Frequencies for age groups

Have you had any management education or training?

	Frequency	Percent
Yes - formal and/ or certified education or training	47	22.7
Yes - informal and/or uncertified education or training	66	31.9
No	94	45.4
Total	207	100.0

Table 4.8. Frequencies for management education

What is your current role at the hospital?

	Frequency	Percent
Member of the Board of Directors	10	4.8
Clinical Manager	7	3.4
Non Clinical Manager	4	1.9
Physician	97	46.9
Licensed Nurse	87	42.0
Member of the Board of Directors & Physician & Clinical Manager	1	.5
Clinical Manager & Physician	1	.5
Total	207	100.0

Table 4.9. Frequencies for roles at the hospital

How long have you been working at this hospital?

Range	Frequency	Percent
0-5 years	62	30.0
6-10 years	62	30.0
More than 10 years	83	40.1
Total	207	100.0

Table 4.10. Frequencies for years of work at the hospital

Which hospital do you currently work in?

	Frequency	Percent
Hospital X	104	50.2
Hospital Y	42	20.3
Hospital Z	61	29.5
Total	207	100.0

Table 4.11. Frequencies for distribution of respondents to hospitals

A Pearson correlation matrix was used to explore the bivariate relationships between all pairs of statement items. This revealed a high degree of association between numerous pairings and this justified a further and more complex investigation using factor analysis. A principal component analysis (PCA) was used for this purpose. In this study, there are 40 variables out of which 9 are demographics and 31 are statements. The statements are designed to measure respondents' perceptions of hospital governance in their employing hospital. Given the bivariate correlation evidence from the 31 statement scores, it is hypothesized that these statement response questions will be correlated and PCA is used to test this. Each of the statement items is measured with a Likert scale where 1 represents "Strongly Agree", 2 represents "Agree", 3 represents "Neither Agree nor Disagree", 4 represents "Disagree", and 5 represents "Strongly Disagree".

There are 3 basic steps in the performance of principal components analysis. The first is assessing the suitability of the data for factor analysis through the sample size and the strength of the relationship among the variables. There is no exact sample size required, but the recommendations are that the bigger, the better. The second step is factor extraction, determining the smallest number of items that can best be used to represent the interrelationships among these items. The third step is factor rotation and interpretation. The term 'rotation' refers to a process that presents patterns of what is called 'loadings' in a manner that is easier to interpret, basically showing which variables come together in the most substantial matrix. There

are 2 main approaches to rotation resulting in either uncorrelated or correlated solutions. Orthogonal rotation or uncorrelated rotation results in solutions that are easier to interpret and report. Oblique rotation or correlated rotation is usually more difficult to interpret. In many situations they often result in similar solutions.

In the principal component analysis in this chapter, the 31 statements were analysed in order to see if they can be reduced into one or few components or factors which explain the relationship among the statement variables. The aims are to find a subset of questions that overall best represent a summary of the collective perception of all staff towards hospital governance.

4.2.1 Principal Component Analysis (PCA)

The first step is to do the principal component of factor analysis without rotation, in addition to obtaining the KMO and Bartlett's test of Sphericity, the Correlation matrix, and the Scree plot, all based on Eigenvalue greater than 1. Coefficients with absolute values greater than 0.30 were selected in order to be obtained in the results; hence, only the loadings or inter-correlations among variables that are above 0.30 will be used.

4.3 Results

4.3.1 Exploratory Factor Analysis using PCA

In the results obtained, the Kaiser-Meyer-Olkin Measure of Sampling Adequacy is equal to 0.731 (should be larger or equal to 0.60). This test checks whether all the variables in the correlation matrix are correlated significantly different than 0; in other words, making sure that there are real correlations between variables, and there are no zeros as a correlation between any of the variables, giving confidence that the variables are significantly correlated. Therefore, the data used meets these assumptions.

The Total Variance Explained and the Scree plot are two of the most commonly used methods dealing with the factor extraction methods for deciding how many components or factors to retain in our solution. Using the Eigenvalue greater than 1 option, SPSS will keep the number of factors or components having the Eigenvalue greater than 1 (see table 4.12). Note that the sum of Eigenvalues is always equal to the number of variables in the

analysis, here equal to 31. So the Eigenvalue divided by 31 gives the percentage of Variance this component retained has. In Extraction Sums of Squared Loadings section of this table, we can notice that only 10 values were retained, meaning that SPSS retained 10 components in the solution. In other words, the 31 variables were reduced into 10 component factors, all having Eigenvalues greater than 1.

In the Scree plot (Figure 4.1) the X-axis plots the components' numbers, and the Y-axis plots the Eigenvalue. This graph plots the same Eigenvalues present in the Total Variance Explained table. The Scree plot is interpreted in a way to keep the components having an Eigenvalue above what is known as the scree, where the line starts to sharply decrease its inclination. As the number of components retained increases (with the increase of the number of variables analysed), the two rules shown in the Total Variance Explained table and the Scree plot tend to agree less often. This can be seen in this study's case, having 10 components retained. If we were to take the Scree plot more into consideration, we should consider retaining and extracting only 4 or 5 components as components 1, 2, 3, 4, and 5 are above a break in the graph between the 5th and the other components after it. The first 4 or 5 components explain or capture much more of the variance than the remaining components. This can also be shown in the Total Variance Explained table (table 4.12).

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.701	15.165	15.165	4.701	15.165	15.165
2	2.356	7.601	22.765	2.356	7.601	22.765
3	2.159	6.965	29.731	2.159	6.965	29.731
4	1.653	5.331	35.062	1.653	5.331	35.062
5	1.471	4.745	39.807	1.471	4.745	39.807
6	1.407	4.540	44.347	1.407	4.540	44.347
7	1.228	3.962	48.309	1.228	3.962	48.309
8	1.181	3.810	52.119	1.181	3.810	52.119
9	1.106	3.567	55.686	1.106	3.567	55.686
10	1.011	3.262	58.949	1.011	3.262	58.949
11	.995	3.211	62.160			
12	.932	3.008	65.168			
13	.859	2.770	67.938			
14	.844	2.722	70.660			
15	.761	2.455	73.114			
16	.744	2.401	75.515			
17	.728	2.349	77.864			
18	.705	2.274	80.138			
19	.634	2.044	82.182			
20	.629	2.029	84.210			
21	.582	1.877	86.087			
22	.579	1.866	87.954			
23	.525	1.694	89.647			
24	.490	1.581	91.228			
25	.475	1.532	92.760			
26	.449	1.449	94.209			
27	.419	1.351	95.560			
28	.395	1.274	96.834			
29	.361	1.164	97.998			
30	.324	1.044	99.042			
31	.297	.958	100.000			

Extraction Method: Principal Component Analysis.

Table 4.12. Principal Component Analysis Total Variance Explained

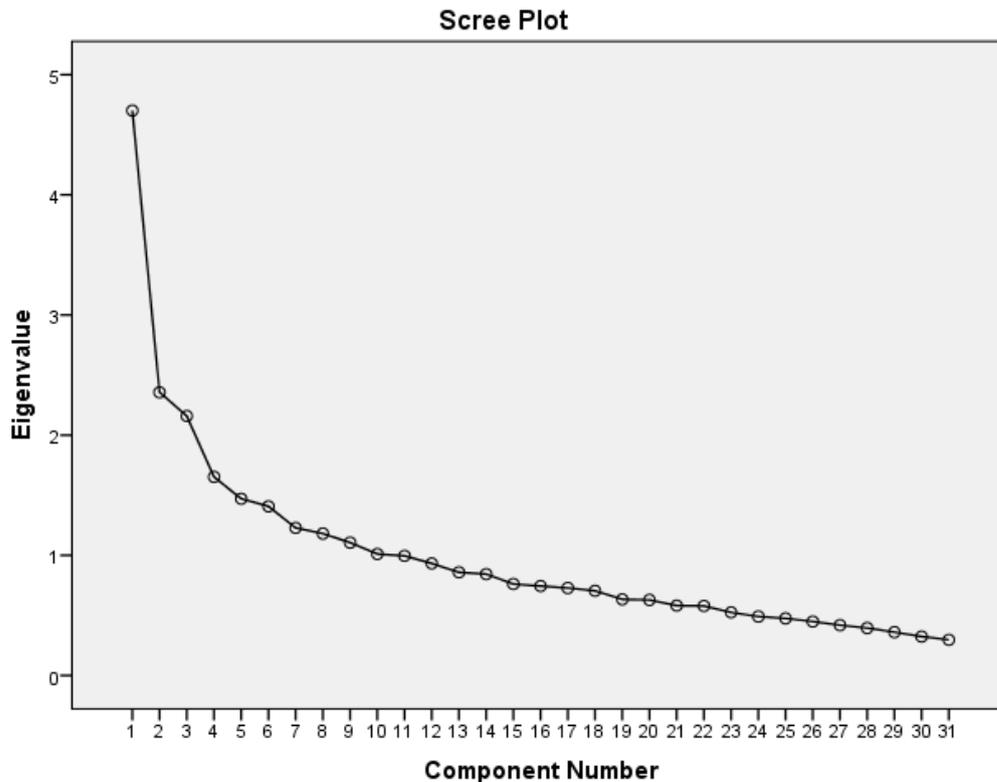


Figure 4.1. Factor Analysis Scree Plot

In order to be able to identify and name the research characteristics of a component, the actual text is looked at in each of the 31 variables (items) to see what it is measuring, and then the variables that load high on each of the components are seen in the Component Matrix (table 4.13). The items that load high would give a good indication on what that component is measuring. The researcher needs to make a qualitative decision about the validity of summarizing these statements as one factor. It is mostly advised to use items that have a value higher than 0.3 because these are the ones that contribute meaningfully to the naming of the component. The Component Matrix gives information about how each of the individual 31 variables relate to the 10 retained components. The numbers in the Component Matrix are called 'component loadings' or 'factor loadings'. They tell how strong the relationship is between each variable and the retained components in the solution. They are also the Pearson Correlation of the variables with the components. The Component Matrix shows the unrotated loading of each of

the items on the 10 components. In this table we can see the loadings which are above 0.30, as it was already set in the conditions of analysis.

Checking the results we obtained in the Component Matrix (table 4.13), it can be seen for example that the variable statement “The Lebanese Order of Physicians strongly represents the physicians’ interests in this hospital” loads or correlates 0.650 on the first component, being the highest correlation among the 31 variables within component 1. It is already known from table 4.12 that component 1 explains the highest proportion of variance in the dataset when compared to the other components.

Component Matrix ^a										
	Component									
	1	2	3	4	5	6	7	8	9	10
The hospital's General Council should have control over the activities of all hospital managers		.409						-.355		
If a serious mistake is made with hospital financial accounting the General Council will hold the relevant manager responsible		.457			.383					
In this hospital all serious clinical errors are investigated appropriately	.567									
Not all hospital managers are responsible for the financial performance of this hospital				.518	.304					
The General Council ensures that clinicians (physicians and nurses) are well-paid in order to ensure efficiency and good care in this hospital	.412				-.334					
It is the responsibility of the General Council to ensure good independent financial audit of this hospital		.582								
The Chief Executive Officer (CEO) of this hospital is well-paid for the level of responsibility he/she has			.572							
There should be more control over how the Chief Executive Officer (CEO) spends this hospital's money		.444	.454	-.364						
All hospital managers should have fixed-term employment contracts which are reviewed and renewed against their performance		.548								
If clinicians (physicians and nurses) develop new clinical procedures that build their own professional status, these may be too risky and expensive for the hospital to support	.403		.367			.496				
It is difficult for hospital managers to prioritize patient safety and quality of patient care		-.465	.500							
It is in the interests of the General Council to pay senior managers high salaries	.639			.317						
The Ministry of Public Health has too much influence on this hospital	.486						.420			
The Syndicate of Hospitals pays too much attention to achieving benefits for the owners of this hospital	.449				.318					
The Lebanese Order of Physicians strongly represents the physicians' interests in this hospital	.650									
Patients are able to rely on the law to hold clinicians (physicians and nurses) to account					-.366		.602			
I would expect non-profit hospitals to be managed better than private, for-profit hospitals			.414			.415				
It is important for non-profit hospitals to make a surplus of money that can be reinvested		.341		.379				.534		
I would expect at least an occasional visit from a member of the General Council to my department		.469								.407
Clinical performance of this hospital is managed appropriately through clear reporting	.606									
External factors like politics or the economic situation of the country have too much influence on what happens in this hospital				.378		.424			.446	
This hospital is well-organized and efficient	.564		-.331		.315					
All managers in this hospital are rewarded adequately for their work	.612									
The General Council does not have enough control over the pay rises of managers			.353					.356		-.342
I am confident that the General Council and the Chief Executive Officer (CEO) have a shared strategic vision for this hospital	.648									
The General Council has the power to direct the Chief Executive Officer (CEO) to act in exceptional circumstances if they see it is for the hospital's benefit	.497								-.348	
The Chief Executive Officer (CEO) in this hospital has more power than the General Council			.443			-.394				
The Chief Executive Officer (CEO) cannot prioritize his/her personal interests over those of the hospital	.415			.358		-.315				-.380
The main objective of the Chief Executive Officer (CEO) is to ensure the hospital makes a surplus of money	.355							-.547		
The Chief Executive Officer (CEO) has an appropriate professional background	.457				-.407					
The members of the General Council have appropriate professional backgrounds	.421							-.346		
Extraction Method: Principal Component Analysis. a. 10 components extracted.										

Table 4.13. Component Matrix

The Communalities table (table 4.14) indicates the amount of variance that the components are accounted for in a variable. In other words, 52% of the variance in the variable “The hospital's General Council should have control over the activities of all hospital managers” is accounted for or explained by the retained components.

Communalities		
	Initial	Extraction
The hospital's General Council should have control over the activities of all hospital managers	1.000	.520
If a serious mistake is made with hospital financial accounting the General Council will hold the relevant manager responsible	1.000	.627
In this hospital all serious clinical errors are investigated appropriately	1.000	.573
Not all hospital managers are responsible for the financial performance of this hospital	1.000	.508
The General Council ensures that clinicians (physicians and nurses) are well-paid in order to ensure efficiency and good care in this hospital	1.000	.491
It is the responsibility of the General Council to ensure good independent financial audit of this hospital	1.000	.537
The Chief Executive Officer (CEO) of this hospital is well-paid for the level of responsibility he/she has	1.000	.607
There should be more control over how the Chief Executive Officer (CEO) spends this hospital's money	1.000	.643
All hospital managers should have fixed-term employment contracts which are reviewed and renewed against their performance	1.000	.539
If clinicians (physicians and nurses) develop new clinical procedures that build their own professional status, these may be too risky and expensive for the hospital to support	1.000	.677
It is difficult for hospital managers to prioritize patient safety and quality of patient care	1.000	.594
It is in the interests of the General Council to pay senior managers high salaries	1.000	.578
The Ministry of Public Health has too much influence on this hospital	1.000	.576
The Syndicate of Hospitals pays too much attention to achieving benefits for the owners of this hospital	1.000	.538
The Lebanese Order of Physicians strongly represents the physicians' interests in this hospital	1.000	.508
Patients are able to rely on the law to hold clinicians (physicians and nurses) to account	1.000	.638
I would expect non-profit hospitals to be managed better than private, for-profit hospitals	1.000	.615
It is important for non-profit hospitals to make a surplus of money that can be reinvested	1.000	.671
I would expect at least an occasional visit from a member of the General Council to my department	1.000	.568
Clinical performance of this hospital is managed appropriately through clear reporting	1.000	.582
External factors like politics or the economic situation of the country have too much influence on what happens in this hospital	1.000	.677
This hospital is well-organized and efficient	1.000	.630
All managers in this hospital are rewarded adequately for their work	1.000	.550
The General Council does not have enough control over the pay rises of managers	1.000	.638
I am confident that the General Council and the Chief Executive Officer (CEO) have a shared strategic vision for this hospital	1.000	.522
The General Council has the power to direct the Chief Executive Officer (CEO) to act in exceptional circumstances if they see it is for the hospital's benefit	1.000	.625
The Chief Executive Officer (CEO) in this hospital has more power than the General Council	1.000	.519
The Chief Executive Officer (CEO) cannot prioritize his/her personal interests over those of the hospital	1.000	.676
The main objective of the Chief Executive Officer (CEO) is to ensure the hospital makes a surplus of money	1.000	.644
The Chief Executive Officer (CEO) has an appropriate professional background	1.000	.573
The members of the General Council have appropriate professional backgrounds	1.000	.630

Extraction Method: Principal Component Analysis.

Table 4.14. Communalities

4.3.2 Parallel analysis

The overall purpose of the PCA modeling is to arrive at the best subset of statement items to represent a collective summary of staff perceptions of hospital governance. In order to make sure which statement items to keep, a parallel analysis was done, as parallel analysis is one of the most accurate factor-retention methods (Hayton et al., 2004). SPSS does not have an option for the parallel analysis, so the *MonteCarlo PCA for Parallel Analysis* software was used for this purpose. The software asks for 3 pieces of information: the number of variables (which equal to 31 in this study), the number of subjects (participants) which is 207 in this study, and the number of replications that is wanted which is set to 100. This software generates random sets of Eigenvalues that are used to compare the Eigenvalues from data of our study. The results below were obtained:

Monte Carlo PCA for Parallel Analysis
Version

3/31/2016 7:21:11 PM

Number of variables: 31

Number of subjects: 207

Number of replications: 100

```

+++++
Eigenvalue #   Random Eigenvalue   Standard Dev
+++++
1             1.8133             .0652
2             1.6974             .0512
3             1.6069             .0446
4             1.5362             .0421
5             1.4642             .0338
6             1.4109             .0333
7             1.3481             .0293
8             1.2969             .0236
9             1.2480             .0231
10            1.2010             .0220
11            1.1572             .0237
12            1.1133             .0229
13            1.0718             .0224
14            1.0259             .0228
15            0.9924             .0258
16            0.9516             .0238
17            0.9135             .0232
18            0.8767             .0205
19            0.8455             .0190
20            0.8099             .0214
21            0.7743             .0223
22            0.7383             .0207
23            0.7070             .0189
24            0.6738             .0212
25            0.6402             .0186
26            0.6071             .0208
27            0.5715             .0217
28            0.5342             .0206
29            0.4995             .0203
30            0.4600             .0206
31            0.4135             .0264
+++++

```

3/31/2016 7:21:19 PM

Monte Carlo PCA for Parallel Analysis

©2000 by Marley W. Watkins. All rights reserved.

Table 4.15. Parallel Analysis to check valid number of components from Factor Analysis

In comparing our study’s Eigenvalues with the Eigenvalues generated by the *Monte Carlo PCA for Parallel Analysis* software, we find that the first 5 components in our study have larger Eigenvalues than those generated by the

Parallel Analysis software. Hence, this tells us that components number 1, 2, 3, 4 and 5 out of the 10 having an Eigenvalue larger than 1 should be retained.

The least correlated statements are then chosen to be excluded in order to reach a phase where the general factor for the perception of hospital governance can be revealed. Therefore, three different methods were used to decide which components are to be retained, and these methods were the Eigenvalues in the Total Variance Explained table, the Scree plot, and the Parallel Analysis.

4.3.3 Demonstrating the best general factor for perceptions of hospital governance: Exclusion of the least correlated statements

After several trials for the exclusion of the least correlated statements, a set of statements were excluded based on the smallest correlations between them and all the other statements. The purpose here is to generate the best subset from the 31 statements that will be used to measure a general component factor of respondents' perceptions of hospital governance.

16 statements covering the major concepts of hospital governance were retained. The statements kept were the following:

- ✓ In this hospital all serious clinical errors are investigated appropriately
- ✓ There should be more control over how the Chief Executive Officer (CEO) spends this hospital's money
- ✓ If clinicians (physicians and nurses) develop new clinical procedures that build their own professional status, these may be too risky and expensive for the hospital to support
- ✓ It is in the interests of the General Council to pay senior managers high salaries
- ✓ The Syndicate of Hospitals pays too much attention to achieving benefits for the owners of this hospital
- ✓ The Lebanese Order of Physicians strongly represents the physicians' interests in this hospital
- ✓ It is important for non-profit hospitals to make a surplus of money that can be reinvested
- ✓ Clinical performance of this hospital is managed appropriately through clear reporting

- ✓ This hospital is well-organized and efficient
- ✓ All managers in this hospital are rewarded adequately for their work
- ✓ I am confident that the General Council and the Chief Executive Officer (CEO) have a shared strategic vision for this hospital
- ✓ The General Council has the power to direct the Chief Executive Officer (CEO) to act in exceptional circumstances if they see it is for the hospital's benefit
- ✓ The Chief Executive Officer (CEO) cannot prioritize his/her personal interests over those of the hospital
- ✓ The main objective of the Chief Executive Officer (CEO) is to ensure the hospital makes a surplus of money
- ✓ The Chief Executive Officer (CEO) has an appropriate professional background
- ✓ The members of the General Council have appropriate professional backgrounds

The principal component analysis (PCA) was run again for this set of statements. The purpose here is to obtain the strongest possible percentage of variance on the first component factor. The result was 5 factors with Eigenvalues greater than 1 as seen in the table below (Table 4.16). With the 16 statement items used, the first component variance explanation has been increased to 26%. The remaining components are unsubstantial and do not appear to make a major contribution to any rational explanation and interpretation.

Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.124	25.777	25.777	4.124	25.777	25.777
2	1.375	8.596	34.373	1.375	8.596	34.373
3	1.316	8.226	42.599	1.316	8.226	42.599
4	1.210	7.560	50.158	1.210	7.560	50.158
5	1.031	6.446	56.605	1.031	6.446	56.605
6	.926	5.787	62.391			
7	.808	5.047	67.439			
8	.759	4.745	72.183			
9	.706	4.413	76.596			
10	.687	4.294	80.890			
11	.598	3.740	84.630			
12	.553	3.455	88.084			
13	.534	3.335	91.419			
14	.513	3.208	94.628			
15	.460	2.877	97.505			
16	.399	2.495	100.000			

Extraction Method: Principal Component Analysis.

Table 4.16. Principal Components Analysis: demonstrating the first general component: perceptions of hospital governance with 16 out of 31 statement items included

Then parallel analysis was done using the *MonteCarlo PCA for Parallel Analysis* software. The results can also be seen in the table below:

Monte Carlo PCA for Parallel Analysis
Version

Number of variables: 16
Number of subjects: 207
Number of replications: 100

```

+++++
Eigenvalue #   Random Eigenvalue   Standard Dev
+++++
1             1.5028             .0637
2             1.3981             .0441
3             1.3117             .0364
4             1.2432             .0345
5             1.1734             .0331
6             1.1171             .0260
7             1.0575             .0302
8             1.0058             .0253
9             0.9524             .0252
10            0.9032             .0261
11            0.8537             .0256
12            0.8023             .0298
13            0.7523             .0289
14            0.6972             .0323
15            0.6476             .0293
16            0.5819             .0348
+++++
3/18/2016  1:22:00 PM

```

Monte Carlo PCA for Parallel Analysis
©2000 by Marley W. Watkins. All rights reserved.

Table 4.17. Monte Carlo confirmation of 16 item first principal component

Comparing the Eigenvalues of the factors obtained through the principal component analysis with the random Eigenvalues generated in parallel analysis, it can be observed that only the first component factor has an Eigenvalue greater than its counterpart in the parallel analysis. Hence, the first component factor only will be retained, being interpreted as the 'Hospital Governance perception' factor.

4.3.4 Recoding Statements

The recording of statements in the questionnaire resulted in scores in such a way that low total factor scores will be those people who have a positive perception of hospital governance, and high scores will be those who have a

less positive perception of hospital governance. The retained statements were checked for negatively designed statements where the Likert scale answers referred to the opposite of the above concept. These statements that were likely to result in negative perceptions were to be reversed along with their values in order to get consistent summative statements where low scores are for a positive perception of hospital governance and high scores are for negative perception.

Only 1 statement was of this category. This was Variable 17. Variable 17 Likert scale scores were reversed. "There should be more control over how the Chief Executive Officer (CEO) spends this hospital's money". This ensures that high scores reflect a perception that more hospital governance is needed and a more negative perception of present state hospital governance.

4.3.5 Individual Scores for factor analysis

It is now possible to compute the principal component, general factor to create individual factor scores for each respondent that will measure their perception of hospital governance in a comparable way to all other respondents. This creates individual scores for the first general factor, giving as a result, a new variable, which is the primary component factor and represents the hospital governance perception score in the 3 studied Lebanese hospitals. The resulting factor score is computed in SPSS and includes the new reversed scoring for variable 17. This analysis in SPSS resulted in an individual score for each of the respondents, representing each of the respondents' perception of hospital governance in the hospital where he/she belongs (DiStefano et al., 2009) so that their score can be consistently and robustly compared with others.

The final Total Variance Explained table (table 4.18) was obtained with the only factor present having a 25.777% variance score, exactly as the one obtained and confirmed through the parallel analysis:

Component	Total Variance Explained					
	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.124	25.777	25.777	4.124	25.777	25.777
2	1.375	8.596	34.373			
3	1.316	8.226	42.599			
4	1.210	7.560	50.158			
5	1.031	6.446	56.605			
6	.926	5.787	62.391			
7	.808	5.047	67.439			
8	.759	4.745	72.183			
9	.706	4.413	76.596			
10	.687	4.294	80.890			
11	.598	3.740	84.630			
12	.553	3.455	88.084			
13	.534	3.335	91.419			
14	.513	3.208	94.628			
15	.460	2.877	97.505			
16	.399	2.495	100.000			

Extraction Method: Principal Component Analysis.

Table 4.18. Principal Component: General perception of Hospital Governance

4.4 Relationship between demographic variables and factor scores

In this section of the data analysis, the purpose is to examine the newly created dependent variable that is the general factor regression score of perception of hospital governance for each individual, and to compare this with different independent variables which are the demographic variables such as: current role at the hospital, the age, the gender, the hospital in which the respondent works, the managerial role at the hospital, the management experience, the leadership role, the management education, and the years of work at the hospital. One-way ANOVAs and Pearson correlation methods are used for this analysis.

For a one-way between groups ANOVA, there should be one dependent continuous variable, and one independent variable with 3 or more groups or levels. In the term one-way between groups ANOVA, one-way indicates that there is one independent variable. The between groups part means that there are different subjects or different cases in each group.

Different one-way ANOVA tests were performed, each having the same dependent variable which is the factor scores for each individual, and one of the independent variables. A T-test was used to compare men and women’s mean average factor scores given that this independent variable has only two categories.

a. Current role at the hospital independent variable

Table 4.19 shows the descriptives of the new dependent variable enabling comparison of mean average scores according to current employment role

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
					Member of the Board of Directors	10		
Physician	97	-.29	.862	.087	-.46	-.11	-2	2
Licensed Nurse	87	.41	.991	.106	.20	.62	-2	4
Total	207	.00	1.000	.070	-.14	.14	-2	4

Table 4.19. Descriptives of the Current Role at the Hospital independent variable compared the dependent variable scores

Since the number of respondents belonging to each of the categories: clinical managers; non-clinical managers; and clinical manager and physicians are each less than 10, these were excluded when studying the relationship between the current role at the hospital and the factor scores.

The assumption of homogeneity of variance was met (Levene’s test= 1.070; df= 5; p= 0.378). The ANOVA confirmed a statistically significant difference between group means (F= 5.970; df= 5; p= 0.00).

Post Hoc Tests (Tukey HSD) tell us exactly where the difference among groups occurred. In the column labeled Mean Difference, the asterisk means that the 2 groups being compared are statistically significantly different from one another at an alpha level of 0.05. The exact significance level can also be seen in the significance column where the *Member of the Board of Directors* and *Licensed Nurse* ($p=0.009$); and the *Physician* and *Licensed Nurse* ($p=0.0001$) are statistically significantly different from one another in terms of the factor scores.

Multiple Comparisons

Tukey HSD

(I) What is your current role at the hospital	(J) What is your current role at the hospital	Mean Difference (I-J)	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
	Physician	-0.213	0.305	-0.93	0.51
Member of the Board of Directors					
	Licensed Nurse	-0.911*	0.306	-1.64	-0.19
Physician	Licensed Nurse	-0.699*	0.136	-1.02	-0.38

*. The mean difference is significant at the 0.05 level.

Table 4.20. Multiple Comparisons: employment role and mean score for perception of hospital governance

Similarly, after determining that there is a significant difference among different groups of the current roles in the hospitals, and after determining where that significant difference was, the comparison of the mean scores was checked for in the mean plot below (Figure 4.2).

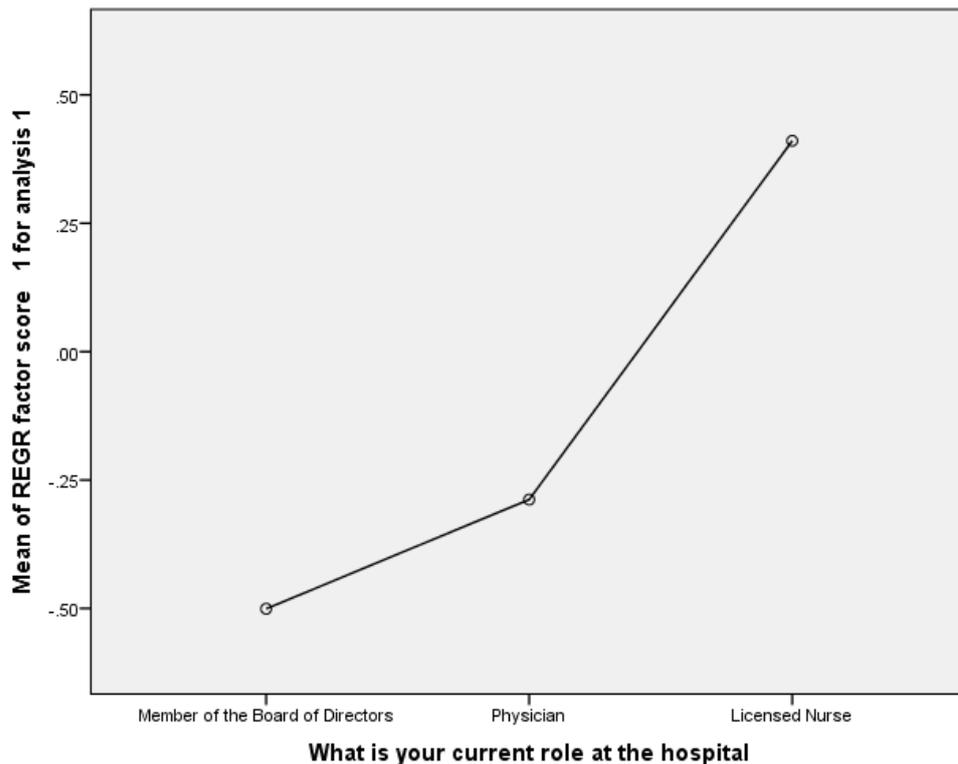


Figure 4.2. Mean plot for perception of hospital governance score: comparison between current roles at hospitals

It can be seen in this plot that the members of the board of directors had the lowest factor scores of around -0.50, while physicians had higher middle scores. On the other hand, licensed nurses had the highest scores (indicating a more critical perception of hospital governance).

b. Gender independent variable

Table 4.21 shows the descriptives of the dependent variable scores as related to gender.

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Male	87	-.13	.978	.105	-.34	.08	-2	3
Female	120	.09	1.009	.092	-.09	.28	-2	4
Total	207	.00	1.000	.070	-.14	.14	-2	4

Table 4.21. Descriptives of Gender compared with the dependent variable scores

For the gender analysis a t-test will be the most suitable test, as for the ANOVA, independent variables must have 3 or more groups. Table 4.21 shows the group statistics of the gender independent variable with respect to the dependent variable.

In table 4.21, it can be seen that there were 87 males and 120 females, with males having a mean factor score of -0.13 and females having a mean factor score of 0.09. The null hypothesis is that there are no significant differences between the means of the factor scores of males and females.

Since the assumption of homogeneity of variance was met (Levene's $F = 0.322$; $p = 0.571$) the regular t value and the significance level associated with this level can be interpreted ($t = -1.597$; $df = 205$; $p = 0.112$). The value of the significance (p) is greater than 0.05 and the null hypothesis is accepted and there are no significant differences between the means of the factor scores of males and females.

c. Age independent variable

Table 4.22 shows the descriptives of age groups when compared to the dependent variable scores.

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
18-25	11	.14	.873	.263	-.44	.73	-1	1
26-35	65	.21	1.015	.126	-.04	.47	-1	4
36-50	94	-.10	.972	.100	-.30	.10	-2	2
51 and above	37	-.17	1.046	.172	-.52	.18	-2	3
Total	207	.00	1.000	.070	-.14	.14	-2	4

Table 4.22. Descriptives of the Age groups compared with the dependent variable scores

There is no violation of the assumption of homogeneity of variances (Levene's $s = 0.061$; $df = 3$; $p = 0.980$). ANOVA showed there was no statistically significant

difference between age groups ($F=1.750$; $df= 3$; $p=0.158$). Tukey HSD post hoc tests confirmed no statistical difference between any of the age groups.

d. Hospital name independent variable

Table 4.23 shows the descriptives of the three hospitals surveyed when compared to the dependent variable scores.

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Hospital X	104	.16	1.102	.108	-.06	.37	-2	4
Hospital Y	42	.19	.947	.146	-.11	.48	-1	3
Hospital Z	61	-.40	.711	.091	-.58	-.22	-2	2
Total	207	.00	1.000	.070	-.14	.14	-2	4

Table 4.23. Descriptives of the three hospitals compared with the dependent variable scores

The assumption of homogeneity of variance was not met (Levene's= 6.380; $df= 2$; $p= 0.002$). Because of this violation, Welch and Brown-Forsythe ANOVA tests were used to examine the difference in mean averages. These tests confirmed statistical differences in the mean average scores (Welch= 10.097; $df= 2$; $p= 0.000$; Brown-Forsythe= 8.210; $df= 2$; $p= 0.000$).

There are statistically significant differences between group means. Since the variances are not homogeneous, we move to the Post Hoc Tests, using the Games-Howell test which is suggested for the case of unequal variances. In the Post Hoc Tests, the multiple comparisons table (table 4.24) is checked. Post hoc tests show exactly where the difference among groups occurred. According to the significance levels shown in table 4.24, it can be seen that Hospital X and Hospital Z ($p= 0.0001$); and Hospital Y and Hospital Z ($p=0.03$) are statistically significantly different from one another, in terms of the dependent variable factor scores.

Multiple Comparisons						
(I) Which hospital do you currently work in	(J) Which hospital do you currently work in	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Hospital X	Hospital Y	-.032	.182	.983	-.47	.40
	Hospital Z	.556	.141	.000	.22	.89
Hospital Y	Hospital X	.032	.182	.983	-.40	.47
	Hospital Z	.588	.172	.003	.18	1.00
Hospital Z	Hospital X	-.556	.141	.000	-.89	-.22
	Hospital Y	-.588	.172	.003	-1.00	-.18

*. The mean difference is significant at the 0.05 level.

Table 4.24. Multiple Comparisons: hospital where you work and mean score for the perception of hospital governance

After determining that there is a significant difference among different groups, and after determining where that significant difference was, the comparison of the mean scores was also checked for in the mean plot below (figure 4.3).

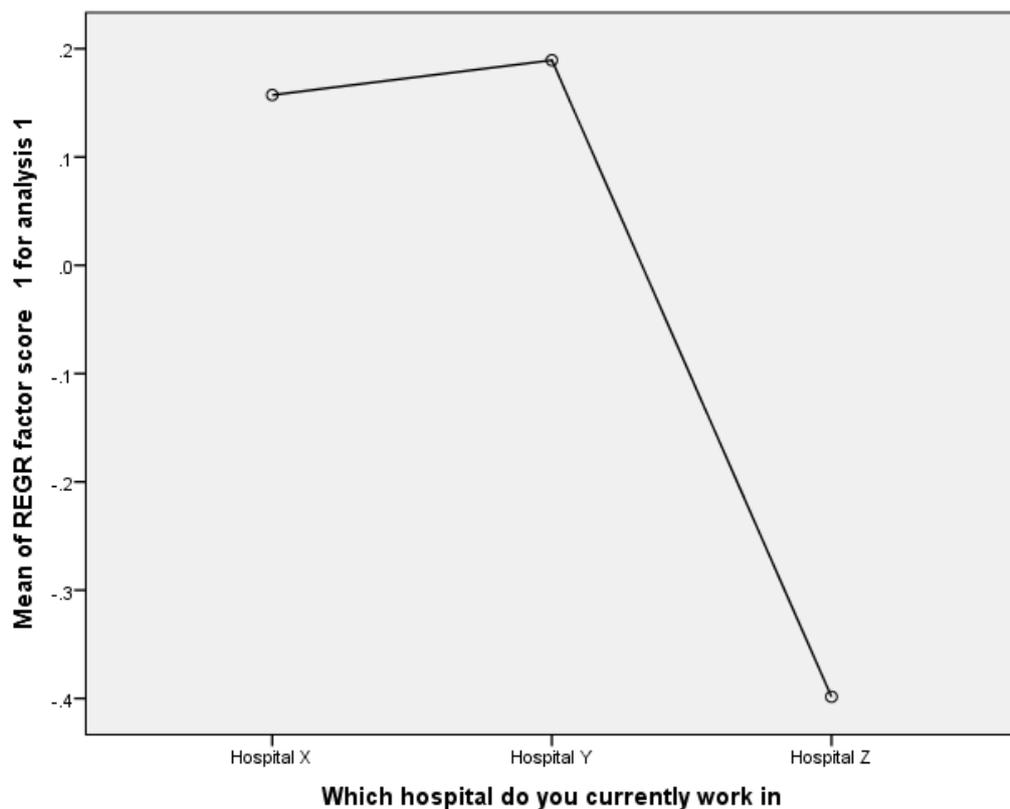


Figure 4.3. Mean plot for score comparison between hospital names variables

The figure above shows that hospital X is statistically different from hospital Z and that hospital Y is statistically different from hospital Z. It also shows that hospital Z has the lowest factor scores among all three hospitals indicating that staff there have a more positive perception of hospital governance when compared to the other two hospitals.

e. Managerial role at the hospital independent variable

Since there are ten groups of managerial roles, measured on an ordinal scale 1 – 10, Pearson correlation score analysis was chosen as a method to check for the correlation and the significance between the managerial role and the dependent factor score variables. There is a significant negative correlation ($r = -0.374$, $p = 0.000$) between the managerial role and the factor score representing the perception of hospital governance. Since the larger the factor score, the smaller the perception of hospital governance; this generally means that the larger the managerial role, the larger the perception of hospital governance. Since the Pearson correlation coefficient is -0.374 , this means that there is a moderate correlation between these two scores. This can be seen in the following figure (figure 4.4).

After determining that there is a significant difference among different groups of the managerial roles at the hospitals, and after determining where that significant difference was, the comparison of the mean scores was checked for in the mean plot below (figure 4.4).

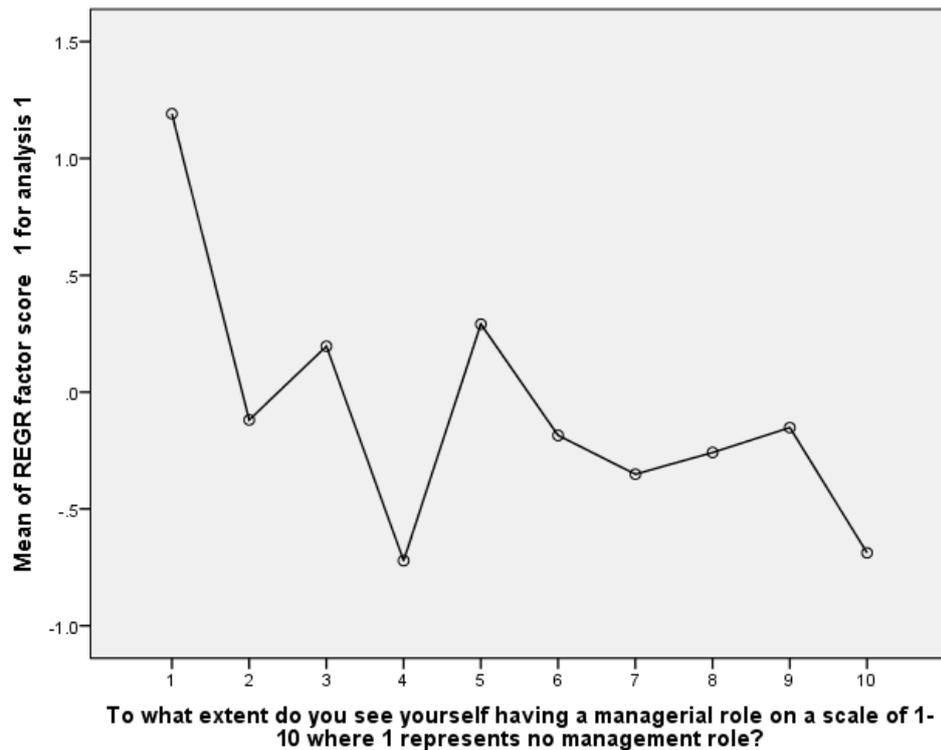


Figure 4.4. Mean plot for score comparison between managerial roles variables

The figure above shows a visual reflection that respondents seeing themselves as not having a large managerial role with a score of 1 had the highest mean for the factor score. This indicates that they were more likely to have a critical perception of hospital governance. However, figure 4.4 also shows some degree of non-linearity in the data with variation in the association for the middle of the ordinal scale.

f. Management experience at the hospital independent variable

Since there are ten groups of management experience, measured on an ordinal scale 1 – 10, Pearson correlation score analysis was chosen as a method to check for the correlation and the significance between the management experience and the dependent factor score variables. There is a significant and moderate negative correlation ($r = -0.382$, $p = 0.000$) between the management experience and the dependent factor score representing the perception of hospital governance. Since the larger the factor score, the smaller the

perception of hospital governance; this generally means that the larger the management experience, the larger the perception of hospital governance. Since the Pearson correlation coefficient is -0.382, this means that there is a moderate correlation between these two scores. This can be seen in the following figure (figure 4.5).

After determining that there is a significant difference among different groups of the managerial experience at the hospitals, and after determining where that significant difference was, the comparison of the mean scores was checked for in the mean plot below (figure 4.5).

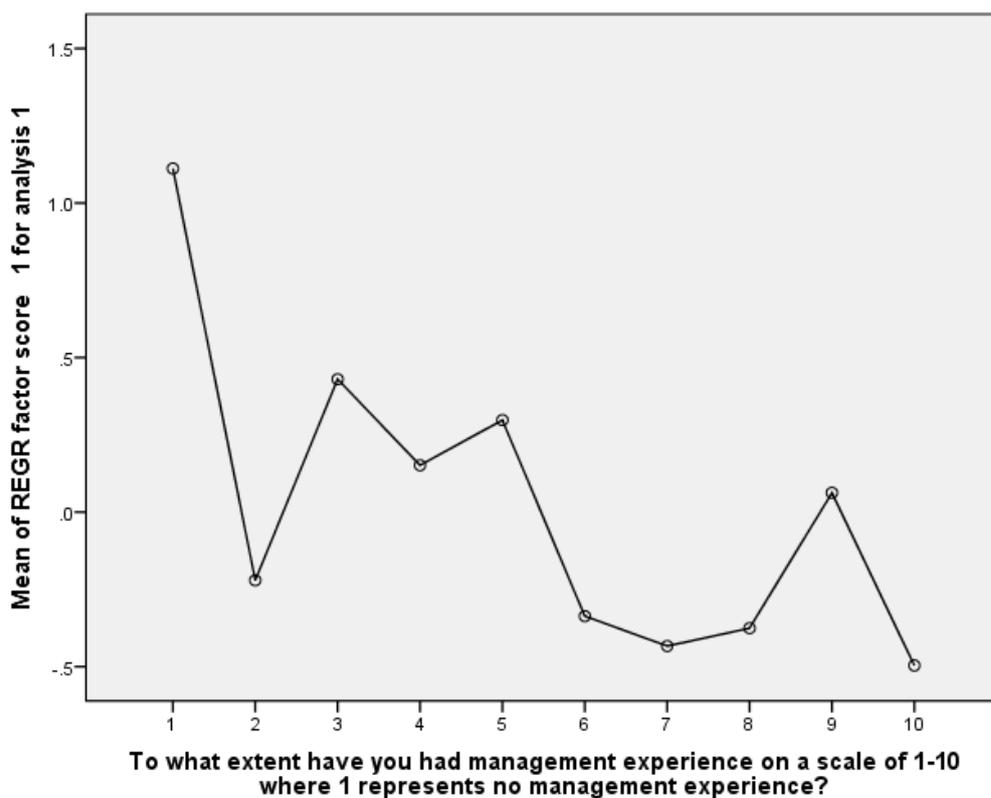


Figure 4.5. Mean plot for score comparison between management experience variables

The figure above shows a visual reflection that respondents having a score of 1 (indicating no management experience) had the highest mean for the factor score and were, therefore, more likely to be critical in their perception of hospital governance. However, figure 4.5 also shows some degree of non-linearity in the data with variation in the association for the middle of the ordinal scale.

g. Leadership role at the hospital independent variable

Since there are ten groups of leadership roles and these represent an ordinal scale 1 - 10, Pearson correlation score analysis was chosen as a method to check for the correlation and the significance between the leadership role and the dependent factor score variables. There is a significant but weak negative correlation ($r = -0.198$, $p = 0.004$) between the leadership role and the dependent factor score representing the perception of hospital governance. Since the Pearson correlation coefficient is -0.198 , this means that there is a small negative correlation between these two scores. This can be seen in the following figure (figure 4.6).

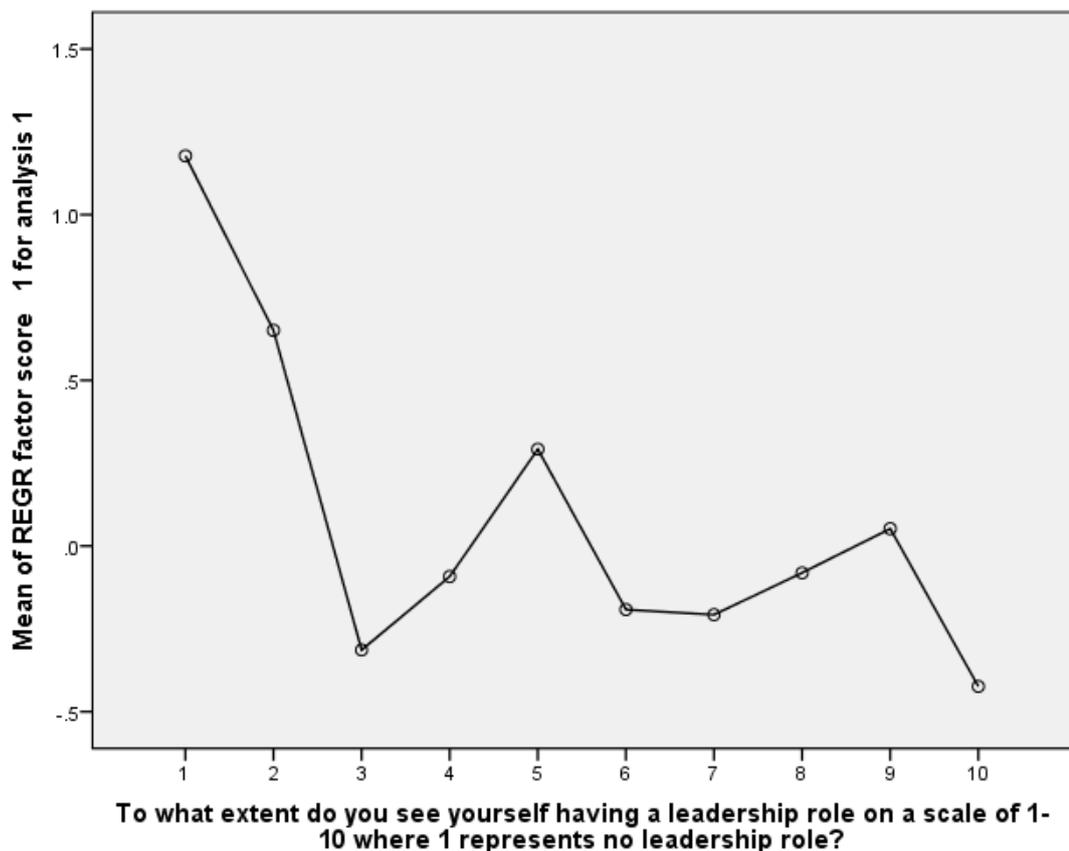


Figure 4.6. Mean plot for score comparison between leadership role variables

The figure above shows a visual reflection showing that respondents having a score of 1 (indicating no leadership role) had the highest mean for the factor score and were, therefore, more likely to be critical in their perception of hospital governance. However, the nonlinear relationship between those respondents scoring between 3 and 9 on the leadership role scale indicates why the Pearson correlation score is weak and unsubstantive.

h. Management education at the hospital independent variable

Table 4.25 shows educational level compared with the dependent variable scores.

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Yes - formal and/ or certified education or training	47	-.24	.920	.134	-.51	.03	-2	3
Yes - informal and/or uncertified education or training	66	-.09	.843	.104	-.30	.11	-2	2
No	94	.19	1.108	.114	-.04	.41	-2	4
Total	207	.00	1.000	.070	-.14	.14	-2	4

Table 4.25. Descriptives of Management Education independent variable compared with the dependent variable scores

The assumption of homogeneity of variance was not met (Levene's= 4.483; df= 2; p= 0.012). For this reason, ANOVA Welch and Brown-Forsythe tests were used to examine the difference in mean averages. These tests confirmed statistical differences in the mean average scores (Welch= 3.213; df= 2; p= 0.044; Brown-Forsythe= 3.652; df= 2; p= 0.028). There are statistically significant differences between group means.

Since variances are not homogeneous, we move to the Post Hoc Tests, using the Games-Howell test which is suggested for the case of unequal variances. In the Post Hoc Tests, the multiple comparisons table (Table 4.26) is checked. This table shows exactly where the difference among groups occurred. According to the significance tests in this table, it can be seen that respondents

having a formal/certified management education or training are statistically significantly different from those who do not have any management education or training in terms of the factor scores representing their perception of hospital governance at the hospitals.

Multiple Comparisons

(I) Have you had any management education or training?	(J) Have you had any management education or training?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Yes - formal and/ or certified education or training	Yes - informal and/or uncertified education or training	-.150	.170	.652	-.55	.25
	No	-.429 [*]	.176	.043	-.85	-.01
Yes - informal and/or uncertified education or training	Yes - formal and/ or certified education or training	.150	.170	.652	-.25	.55
	No	-.279	.154	.170	-.64	.09
No	Yes - formal and/ or certified education or training	.429 [*]	.176	.043	.01	.85
	Yes - informal and/or uncertified education or training	.279	.154	.170	-.09	.64

*. The mean difference is significant at the 0.05 level.

Table 4.26. Multiple Comparisons

After determining that there is a significant difference between different levels of management education at the hospitals, and after determining where that significant difference was, the comparison of the mean scores was checked for in the mean plot below (figure 4.7). This confirms that those without management education or training are more likely to have critical perceptions of hospital governance.

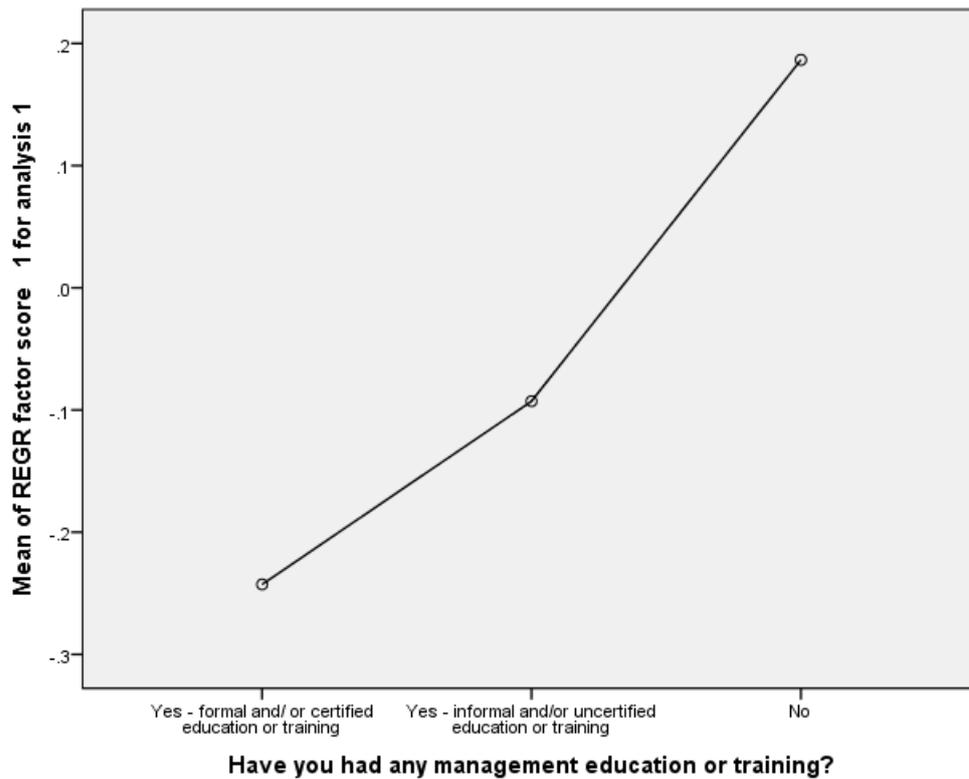


Figure 4.7. Mean plot for score comparison between management education variables

i. Years of work at the hospital independent variable

Table 4.27 shows the descriptives of number of years worked compared with the dependent variable scores.

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
0-5 years	62	.19	1.149	.146	-.10	.48	-2	4
6-10 years	62	-.30	.721	.092	-.48	-.12	-2	2
More than 10 years	83	.08	1.020	.112	-.14	.30	-2	2
Total	207	.00	1.000	.070	-.14	.14	-2	4

Table 4.27. Descriptives of the years of work at the hospital independent variable compared with the dependent variable scores

The assumption of homogeneity of variance was not met (Levene's= 4.929; df= 2; p= 0.008). For this reason, ANOVA Welch and Brown-Forsythe tests were used to examine the difference in mean averages. These tests confirmed

statistical differences in the mean average scores (Welch= 5.604; df= 2; p= 0.005; Brown-Forsythe= 4.384; df= 2; p= 0.014). There are statistically significant differences between group means.

Since variances are not homogeneous, we move to the Post Hoc Tests, using the Games-Howell test which is suggested for the case of unequal variances. In the Post Hoc Tests, the multiple comparisons table (table 4.28) is checked. This table shows exactly where the difference among groups occurred. According to the significance tests in this table, it can be seen that respondents that have been working 0-5 years at the hospital are statistically significantly different from those who have been working 6-10 years at the hospital (p=0.014). It can also be seen that respondents that have been working 6-10 years at the hospital are statistically significantly different from those who have been working for more than 10 years (p=0.26), in terms of the factor scores representing the perception of hospital governance at the hospitals.

Multiple Comparisons

Dependent Variable: REGR factor score 1 for analysis 1

Games-Howell

(I) How long have you been working at this hospital	(J) How long have you been working at this hospital	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
0-5 years	6-10 years	.492 [*]	.172	.014	.08	.90
	More than 10 years	.113	.184	.813	-.32	.55
6-10 years	0-5 years	-.492 [*]	.172	.014	-.90	-.08
	More than 10 years	-.379 [*]	.145	.026	-.72	-.04
More than 10 years	0-5 years	-.113	.184	.813	-.55	.32
	6-10 years	.379 [*]	.145	.026	.04	.72

*. The mean difference is significant at the 0.05 level.

Table 4.28. Multiple Comparisons: time working and mean score for perception of hospital governance

After determining that there is a significant difference among different types of the years of work at the hospital, and after determining where that significant difference was, the comparison of the mean scores was checked for in the mean plot below (figure 4.8).

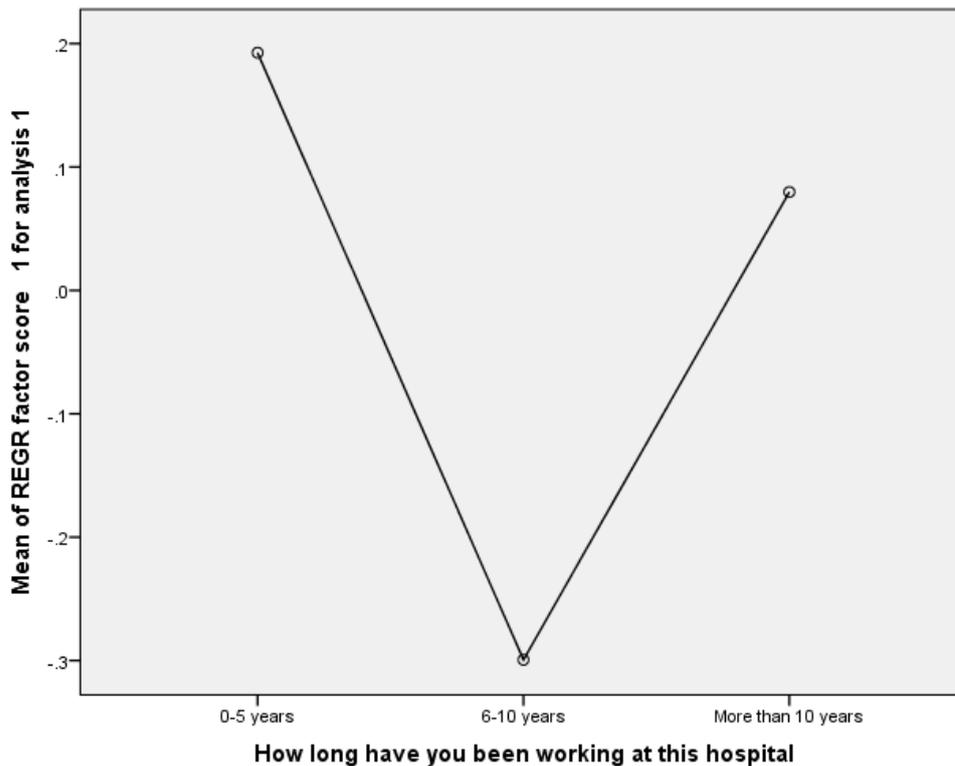


Figure 4.8. Mean plot for score comparison between years of work at the hospital variables

The figure above shows a visual reflection of what was interpreted from the Multiple Comparisons table above, showing that respondents that have been working 0-5 years at the hospital are statistically different from those who have been working 6-10 years at the hospital, and those who have been working for 6-10 years at the hospital are statistically different from those who have been working for more than 10 years, in terms of the factor scores representing the perception of hospital governance at the hospitals. It is those who have been working between 6-10 years who are more likely to have a positive perception of hospital governance.

As a summary of the results of the relationship between demographic variables and the identified factor scores, members of the board of directors had the most consistent perception of hospital governance (lowest factor score), followed by non-clinical managers, physicians, clinical managers, clinical managers and physicians, and licensed nurses respectively. Members of hospital Z had the most consistent perception of hospital governance, followed

by members of hospital X and hospital Y respectively. The factor scores of hospitals X and Y were close while that of hospital Z was much smaller. Concerning the managerial roles, respondents with the lower managerial roles showed lower perception of hospital governance, while those with higher managerial roles had higher perceptions. Similarly, those with small management experience had lower perceptions of hospital governance than those with higher management experience. Likewise, respondents with small leadership roles had lower perceptions of hospital governance than those with higher leadership roles. Respondents who had formal and/or certified education or training had higher perceptions of hospital governance than those having informal and/or uncertified education or training, which had higher perceptions of hospital governance than those with no education or training. Respondents who have worked at the hospitals for 0-5 years had the least consistent perception of hospital governance. Those who worked for 6-10 years had the most consistent perception, and those who worked for more than 10 years had an average perception. On the other hand, there were no significant differences between the means of the factor scores of males and females, and there were no significant statistical differences between any of the age groups; so there were no significant differences between any of the respondents' perceptions of hospital governance based on genders and age groups.

This section has demonstrated some important independent effects on staff perceptions of hospital governance in the sample of Lebanese Hospitals. These will be followed up further in the thesis, in particular, with the use of forthcoming qualitative interviews. The quantitative data has shown that there is evidence of single factor that illustrates how the collective of staff surveyed are most likely to understand and perceive hospital governance. This comprises of a number of different items used to ask questions that relate to previous literature and studies about corporate and clinical governance. Once this collective factor had been evident and each respondent was given an individual score calculated from this factor model, it was possible to examine what demographic aspects might be associated with differences in overall perception of hospital governance. Those who put less emphasis on their own managerial role and education, perhaps seeing themselves more as a professional clinician

than a manager, were more likely to be critical in their perception. Conversely those in more senior management roles were likely to be positive in their perceptions. In addition, there were some significant differences in the average perceptions of hospital governance measured between the three hospitals studied.

Chapter 5

QUALITATIVE ANALYSIS

In the qualitative section of data collection, the semi-structured interviews targeted 8 managers from the three hospitals studied. The interview questions were designed in a way to cover the research questions and the basic concepts of both corporate and clinical governance. Different themes were focused on to be studied in these interviews. These included responsibility, accountability, CEO Power, board's/owners' power, relationship of clinicians and management, relationship of CEO and board/owners, incentivisation and remuneration, performance, communication, knowledge, conflict of interest (agency theory/agency problem), control, audit, stakeholders, and quality and safety. Detailed questions can be seen in the Methodology and Methods chapter.

Interview questions were designed to add knowledge to the analysed data that was collected quantitatively through surveys. The survey identified areas of responsibility along with key roles and relationships within the corporate governance structure, while in the interviews, respondents were asked to describe structures of management and governance. Many of the interviewees spoke about those structures as they applied to the hospital they work in. Based on this, we see that the place where someone works therefore affects their perception of corporate governance. In addition, the survey collected the respondents' opinions at a single point in time whereas the interviews allowed participants to reflect on events and how these too affect corporate governance. The qualitative data was drawn upon to support the results of the quantitative data, and add knowledge on the relationships between corporate and clinical governance, on the influence of external factors, external stakeholders on the internal hospital governance, and on corporate governance events that happened to take place at these hospitals. It also provided knowledge on how managers describe the corporate governance events and their effect on the managers' degree of perception of hospital governance. Critical realism is the theoretical framework used to analyse both the quantitative and qualitative data.

Examples of how critical realism informed the analysis of qualitative data are included at the end of each main sub-section.

5.1 Interviewee understanding of corporate governance

In order to add depth to what we know about how managers perceive corporate governance, a set of questions was prepared which enabled interviewees to articulate their perceptions along with their views on the relative importance of specific aspects of governance at their hospitals. Different major concepts of corporate governance that were identified in the literature review and included in the survey questions were covered in the interview questions. The main themes that covered the main concepts of corporate governance in the hospital setting were as follows.

5.1.1 Mission and Vision

The mission of the congregation is posted on their website. For confidentiality purposes, only some main points will be mentioned here, in a paraphrased form:

The purpose of our mission is devotion in service. To best fulfill the mission of hospital, educational, and socio-pastoral, our homes are established in urban areas, popular areas, and remote villages, where the need is pressing. We strive to provide useful services that are mostly humanitarian and meaningful. Our sense of duty and our geographical location ensure that our services are rendered to any person requesting, whether Lebanese or foreign, and whatever their confession might be. In devoting ourselves we do not distribute money, but on the contrary, we try to make everyone dignified by giving him the means to react. That is what we do, that is what our homes insure and assume, this is what we always want to be able to undertake and guarantee for peace, freedom, equality, and fraternity reign in our country Lebanon.

It is noted that the mission statement of the congregation, although similar to mission statements of non-profit hospitals with spiritual background, does not include descriptions of purposes regarding the quality of care and safety of

patients. Similar mission statements of hospitals worldwide can be seen on the following link:

https://www.missionstatements.com/hospital_mission_statements.html

As for documentation describing the strategic vision of the hospitals, I was told that these are confidential. In order to cross-reference this, a manager at hospital X was asked whether they have a strategic vision and if so, whether we can have access to it. His answer was “Yes there is a strategic plan - it is available, but I cannot give you a copy as it is confidential for the hospital”. It is interesting that the shared strategy document is described as confidential – often strategy documents are public facing and used as a way of describing the vision of the organisation to external stakeholders.

5.1.2 Boards of directors

Based on questions asked to the presidents of two of the three hospitals, it was clear that the presidents of each of the hospitals are also on the general council. The board of directors of the three hospitals is known in Lebanon as the general council of the three hospitals. In general, the term ‘general council’ has lots of different designations according to the field it is used in: In education, it is used for the corporate body of all graduates and senior academics of the University; In medicine, it is used for the regulator of the medical profession (in the United Kingdom); In politics and government, it is used to refer to the legislative body of governmental institutions; In trade it is used for the highest decision-making body; and finally, in Church, it is used to refer to a meeting of the bishops of a whole church convened to discuss and settle matters of church doctrine.

Based on the interviews, it was also proven that there is a clear misunderstanding of the differences between the terms ‘board of director’ and ‘committee’, as some of the managers used the term ‘board of directors’ while they were referring to the ‘Medical committee’ of which they are members. Even some of them described themselves as members of the boards of directors, while they meant ‘members of the medical committee’ or other committees. This was seen in the interchangeable use of the terms ‘board’ and ‘committee’ by participants to describe the same group or meeting. The website of the congregation that the hospitals correspond to and unofficial interviews with the

presidents of two of the three hospitals confirmed that the general council is the board of directors which undertakes the roles and duties of a board and in this case only constitutes of nuns. The general council is constituted of five nuns: Chairman (named as the 'Superior General' of the board), advisor and general nun, second advisor, third advisor, fourth advisor and general secretary. Assisting the board are a general treasurer and a head of novices, which are also nuns. This general council is elected for a period of six years and headed by the superior general (chairman).

5.1.3 Hierarchal structure

Based on the interviews performed with managers from the three different hospitals, it was noted that interviewees' use of terms to describe roles and positions within the organisational hierarchy at the hospitals were inconsistent with those formally used. For example, the term executive director was used differently in some hospitals compared to in others. Some hospitals referred to the general manager as an executive director. This may be accurate internally but is uncommon worldwide, as an executive director is a chief executive officer (CEO) or managing director of an organisation, company, or corporation. The title 'executive director' is widely used in North American non-profit organisations, though many United States non-profits have adopted the title president or CEO. Moreover, in the hierarchal system of the hospitals studied, there is also a president for each hospital, responsible for the hospital in general, and being under the general council in the hierarchy. The president, being a nun, is in the hierarchy above the general manager of the hospital, and is responsible for the overall functioning of the hospital. Moreover, according to the hierarchy of the hospitals, there is a Chief Executive Officer (CEO) above the presidents of the hospitals, and below the general council.

Based on all the descriptions of the hierarchy of the board from the interviewees, and based on background knowledge on the hierarchal structure of the three hospitals under study, figure 5.1 shows the model of the hierarchy in the three hospitals X, Y, and Z.

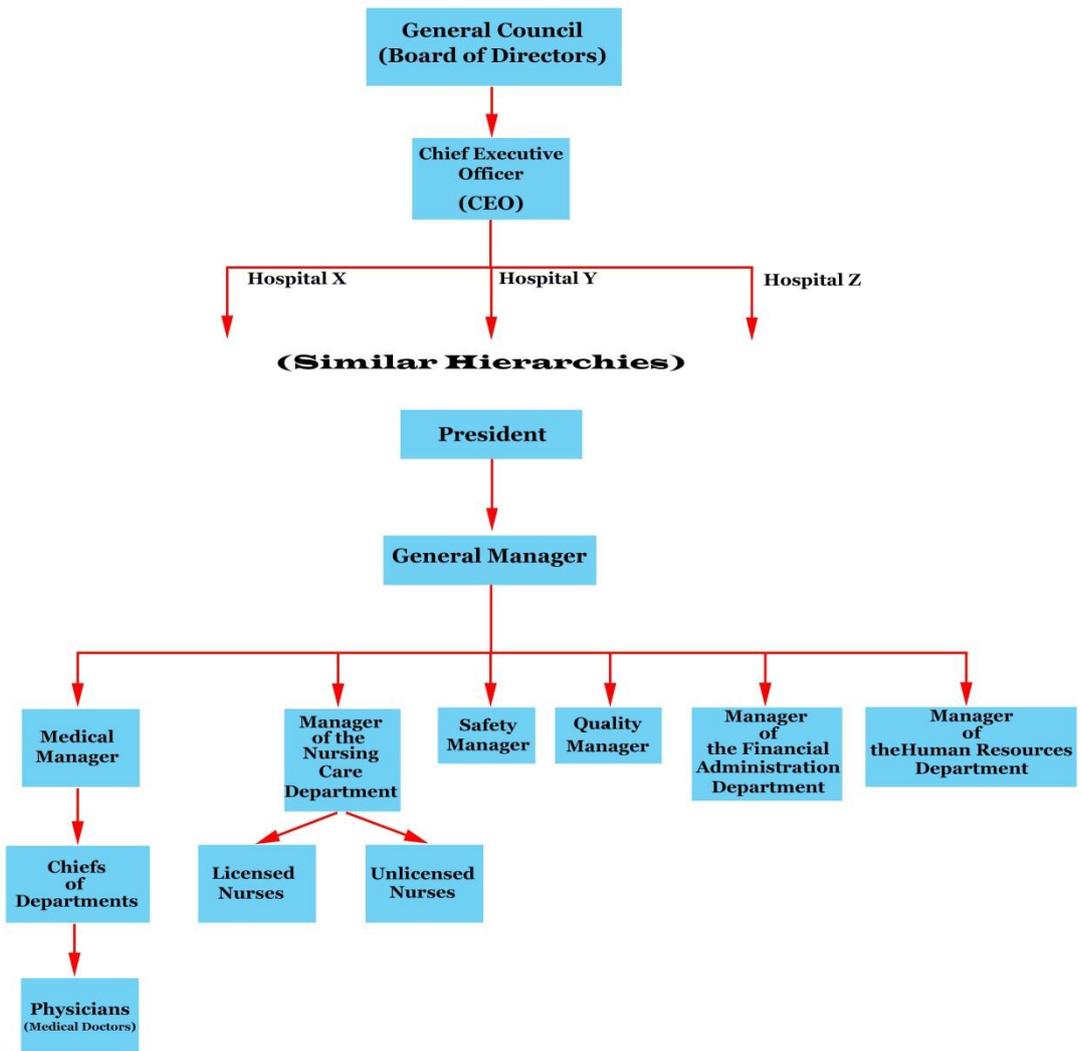


Figure 5.1. Hierarchical structure of the three hospitals studied

It should be also noted that based on questions on the hierarchical structures and the communication along the hierarchies of the hospitals, it was noticed that most interviewees described the internal structure of the hospitals they work in adequately, but none of them went higher into the hierarchy to reach the general council. In general, interviewees rarely mention a management structure beyond their own hospital. This can be interpreted as if, in the interviewees' perception of things, the three hospitals are detached from each other. This shows that interviewees (being managers) are either not giving importance to the role of the chief executive officer and general council, or they are not aware of their presence or organisational role.

5.1.4 Communication along the hierarchy

From the answers of all interviewees, it can be interpreted that direct communication takes the primary focus and is the primary method of communication between all managers and staff in the three hospitals. Written forms of communication, like reports, emails, and messages seem to be the secondary forms of communication. Meetings are also a third form of communication mentioned by most of the interviewees, relating it mainly to communication on the managerial level, and particularly in the medical committees' meetings.

5.1.5 Accountability

When asked about to whom does each of the interviewees consider themselves accountable to, answers were mostly similar in that each of them considered him/herself accountable to one or more of the following: the hospital they work for, the president of the hospital they work for, the executive director of the hospital they work for, the organisation in general, the congregation which includes the hospitals, the medical committee of the hospital they work for, the general manager of the hospital they work for, and to the chairman of the general council.

5.1.6 Control and Power

A manager at hospital X referred to the control that the general council (board of directors) must have over the CEO.

“The general council must have good control over the CEO – the CEO should not have the total power over everything without communicating and taking instructions from the general council”.

When asked about control, the answers of the interviewees varied among different answers. This shows the differences between the perceptions of the interviewees towards who is in control in their hospitals in terms of finance, power, decision making, and politics.

Financially speaking, when asked about who is in control of the financial performance at their hospitals, answers of the interviewees in hospital X were: the new committee taking the place of the CEO after he had to leave, the

president of the hospital, and the financial manager of the hospital. The answers of interviewees in hospital Y were: the general management of the three hospitals (headed by the CEO), the financial management of the hospital, the executive director, the Chief Financial Officer (CFO) responsible for the financial performance of the three hospitals, and a manager said “I do not really know during this phase who is financially in control”. On the other hand, answers of interviewees in hospital Z were: the general manager of the hospital and the nuns.

Speaking about power, when asked about who is in control in terms of power at their hospitals, answers of the interviewees in hospital X were: the new committee taking the place of the CEO after he had to leave, and the president of the hospital. The answers of interviewees in hospital Y were: the president of the hospital, the management committee, each of the managers in his/her own department, the CEO, and the general manager of the hospital. On the other hand, answers of interviewees in hospital Z were: the head (chairman) of the general council, the nuns, and the physicians.

Concerning control in decision making, when asked about who is in control in terms of decision making at their hospitals, answers of the interviewees in hospital X were: the new committee taking the place of the CEO after he had to leave, each manager in his/her own department, the president of the hospital, and the financial manager. On the other hand, the answers of interviewees in hospital Y were: the management committee, and the president of the hospital for big decisions. The answers of interviewees in hospital Z were that control in decision making is common and mutual between different entities including the nuns.

In terms of politics, when asked about who is politically in control of the hospitals, answers of the interviewees in hospital X were: the new committee taking the place of the CEO after he had to leave, and the nuns being the owners. The answers of interviewees in hospital Y were: the president of the hospital, the congregation in general, and the management. Finally, the answers of interviewees in hospital Z were: strong and well-known physicians of the country, strong religious authorities, the nuns, and “Bkerke” (the center of the Maronite Catholic Patriarchate). All of these answers prove that in relation to

control, interviewees had diverse perceptions of control at each of the three hospitals.

It was also noticed that only a manager at hospital Z mentioned the general council in his answers, specifically the head of the general council, when referring to control in the hospital. He said: “in terms of power, the control is in the hands of the head of the general council, who is a nun”. This supports the fact that the perception of the role of the general council is low, possibly because of its minor role in the direction of the hospitals.

5.1.7 Understanding of corporate governance and critical realism

Corporate governance in the hospitals studied was not understood by interviewees and respondents to the surveys as ‘right’ or ‘wrong’. The interview schedule and the survey statements were designed to check whether interviewees and respondents had strict positions from whether the corporate governance at the hospitals they are working in is adequate. From a critical realism perspective, the actual structure described in figure 5.1 describes the generative mechanisms underpinning the corporate governance of the three hospitals. Clearly, interviewees (and we can therefore assume respondents to the survey) understand and experience these mechanisms differently. As we shall go on to see, their understanding is influenced by ‘events’ that cause them to experience or re-experience corporate governance mechanisms differently.

5.2 Systems of management and corporate governance: Understanding the agency problem in hospital governance

When studying governance in hospitals, this embraces all the subcategories of governance, including the clinical governance. It also includes all the aspects related to the functioning of the hospitals, their mission and vision, their boards of directors, their hierarchal structure and communication along the hierarchy, stakeholders and their involvement in the overall system of the hospitals, external factors affecting the internal performance, accountability, control and power, CEO power, the relationship of clinicians with the management, knowledge and experience, and conflicts of interest and the agency problem.

Empirically, interviewees were clearly immersed in clinical practice and the systems through which the hospitals attempt to ensure good care and good clinical governance. For many, the corporate governance of the hospital is something distant that they have no control over compared to clinical governance which affects their day-to-day working lives and the experience of the patients they care for.

5.2.1 Quality and safety

The perception of all interviewees to the standard of care was positive. They all described the hospitals in which they work in as having a good standard of care. For example, when asked about the standard of care at each of the hospitals, a manager at hospital X said that “in my opinion, in terms of physicians and nurses, its standard of care is very good”. Another manager at the same hospital said “yes, it has a good standard of care; not an outstanding level, but a good quality of care”. A third manager at the same hospital said “patient-safety wise, everything is properly implemented”. Similarly, a manager at hospital Y said “with the things that we already have and already work with, I may say that we have a very good standard of care”, while another said “Yes, and this is reflected by the low rate of infections”. In hospital Z, a manager answered by “Yes, I see it has a good standard of care both from the quality and safety aspects”, while another manager said “Yes, it has a good standard. I may say that it is not the best, but with the conditions and capabilities we have, we are offering the best we can offer”.

As for dealing with errors at the three hospitals, hospital X has a ‘Mortality and Morbidity’ committee that studies and investigates all the mistakes which take place with the physicians and the nurses. This committee works in collaboration with the patient safety and the quality departments. So, in hospital X, the system of dealing with mistakes is set appropriately and is well-known. When asked if errors are dealt with well at the hospital, one manager at hospital X answered by referring to the methods of dealing with errors “I may say that they are not the best, but with the conditions and capabilities we have, we are offering the best we can offer”. Another manager said

“On a weekly basis, we have a report of all errors and sentinel events. They are divided into different fields: medical, nursing, and operational. All

of these reports are sent to the chiefs of departments that are responsible for the cases accordingly”.

In hospital Y, there is also a committee that follows all mistakes. This committee is related to the quality and hygiene personnel. A manager mentioned that by saying:

“There is a committee which follows all mistakes. Every declaration that takes place is followed up by this committee. It takes action accordingly after the case’s analysis and investigation”.

But in this hospital (hospital Y), there seems to be a problem with the declaration of mistakes: employees seem to be afraid of declaring mistakes, and this is causing a problem of declaring mistakes appropriately. A manager said:

“I always inform the staff and clinicians that they should always declare the mistakes in order to be prevented in the future. It is a matter of culture: they have to declare in order for the case to be studied further and for the responsible personnel to focus on preventing its occurrence in the future”.

He also said that “there are some mistakes that happen sometimes and that are hidden and few or no one knows about them”. Another manager said

“we informed all the personnel that declaring mistakes is for their own sake. We ask them for declaration not with a purpose of taking actions and judging them, but because sometimes mistakes happen as a result of bad systems and not because of personal mistakes”.

In hospital Z, there is also a committee that evaluates the problem and records it. Moreover, cases of non-medical mistakes are also investigated by the quality department. A manager at this hospital said:

“we have a committee. Whenever there is a problem, this committee evaluates the problem and records it. Sometimes even cases of death are studied whenever someone suspects any mistake”.

Another manager said:

“All the errors, whether medical or non-medical, are prone to a report system. This system is related to the quality department. Here, an investigation takes place for every case and the error is followed till the end and the department acts accordingly.”

Therefore, in all three hospitals, the methods of dealing with errors appeared to be clear and are well-known by the managers. There also seems to be a proper structure for dealing with mistakes at the three hospitals. A major problem lies in the lack of declaration of mistakes.

The responsibility for patient care quality and safety in the three hospitals lies in the hands of a manager responsible for the safety and security of patients, and another responsible for the quality of care. Each of the respondents referred to the two managers differently; some related them to a committee, and others specified their presence and their reporting requirements.

Based on all the answers of the interviewees and especially on the questions related to the standard of care at the three hospitals, it has been shown that the clinical knowledge, based on the opinion of the interviewees, is good. A manager at hospital X for instance, said that “in my opinion, in terms of physicians and nurses, its standard of care is very good”; referring to the hospital’s standard of care reflected by the clinical knowledge. Another manager at hospital Y said: “with the things that we already have and already work with, I may say that we have a very good standard of care”. Furthermore, a manager at hospital Z said: “Yes, I see it has a good standard of care both from the quality and safety aspects”.

5.2.2 Hospitals’ performance

Knowledge of the methods of performance measurement and performance indicators used in the hospitals is an important point in terms of corporate governance, as good performance measurement tools and their adequate implementation result in a proper governance system and improve clinical governance where safety and quality will be protected (Haynes, 2003).

Clear methods of performance measurement were shown to be present in hospital X. Moreover, the perception of their presence and the knowledge of their types and methods of implementation were shown to be high by the interviewees. On the other hand, in hospital Y, it can be interpreted that there may be a lack in the knowledge and maybe a lack in the implementation of the proper methods of performance measurement. Hospital Z was similar, in this case, to hospital X, where KPIs (and the collection of points- related to KPIs) are used to measure performance.

The methods of performance measurements described by interviewees at each of the three hospitals are shown in table 5.1 below:

Hospital	Methods of performance measurements
Hospital X	Key Performance Indicator (KPI)
	Satisfaction of patients, physicians, nurses, and the other personnel
	Every manager does a yearly evaluation to the employees of his department
	Number of nosocomial infections
	End of stay of patients
	Complications post-operation
	Bad or false indications
	Number of sentinel events
	Occupancy rate
	Number of surgical operations that are re-performed
	Profits and turnover rates
Hospital Y	Progress of the hospital
	Weak points based on previously set job descriptions
	Every service has certain indicators that are frequently measured
	Based on action plans, checkups are done on whether the deadlines are met or not
	Audit files which aid in measuring the performance
	External auditors that aid in performance measurement
Hospital Z	A grading system, where each of the clinicians and staff collects points based on his/her performance, and then the total points collected must be enough for the person to be able to continue his/her job in the hospital
	Performance indicators referred to as KPI
	Each department has its own KPIs that are quarterly presented to the management

Table 5.1. Methods of performance measurements at each of the three hospitals

Based on the answers of all the interviewees in the three hospitals, there is a clear contradiction on whether contracts' renewals are based on the performance of the individuals. Some have answered that the contracts' renewals are based on the performance, others have answered that in some times they are renewed based on performance, others have answered that few are the contracts in the hospitals, and others have answered that there are no contracts in the hospital to be renewed. For example, a manager at hospital X stated that "It depends. Some contracts are renewed according to performance and others are not." Another manager at the same hospital said

"Very few are those who work here based on contracts. But for sure, concerning those who are performing badly, we work in a way to terminate their job functions at the hospital."

Similarly, one manager at hospital Y said:

"In Lebanon, the system does not require to have contracts with physicians in private hospitals, so I cannot answer on behalf of those who have contracts. But I am sure that in the other fields, performance is taken into consideration, and some employees didn't continue their work at the hospital due to the lack of performance",

while another said: "As far as I know, there are no written contracts here."

Likewise, a manager at hospital Z said: "Performance is taken into consideration most of the times for the contracts' renewal, but it is not the only criteria." Therefore, based on their answers, and putting the clear contradiction aside, we may say that whenever there are contracts, performance is taken into consideration for their renewal.

5.2.3 Efficiency and Degree of Organisation

In contrast to the widespread view that care at the three hospitals was good, responses on the question of the efficiency and organisation of the hospital were less positive. In answer to questions on whether the hospital interviewees worked in is well-organized, two managers in hospital X saw it as not being well-organized and gave their recommendations for a better organisation. For example, one manager said:

"No. It could be improved using the same strategy as I mentioned before for improving the efficiency (There should be a more homogeneous management. It should be able to stop the corruption, the waste, and

squandering of money, and specify more accurately the exact roles and requirements of each of the managers, because the roles are overlapping in this hospital)",

and the other said:

"Not very well-organized. It needs more adjustment. The responsibilities of individuals should be better specified and implemented. Each individual should be more responsible in the field where he/she is".

A third manager saw that the hospital is well-organized with the need for improvements; she said:

"I cannot talk financial wise, but in terms of organisation and procedures I can say yes for sure. Moreover, we should update our procedures to become more efficient. For example, if for the patient is to go from point A to point B, he/she needs to go through 6 phases. We can work on reducing them to 3 phases. This leads to the use of fewer personnel, less resources, etc..."

As for hospital Y, managers in general do not see the hospital as being well-organized. They did not clearly specify the problems, and did not give clear recommendations. One manager said:

"there are lots of things to be improved in this aspect. There have been some problems in the hospital that need more organisation. So again I say that yes, there has to be some improvements in organisation."

Another manager said: "I will simply say that there are many things that we can work on improving". And a third manager said: "I see that we need better regulations in some places- The head of the pyramid should control things in a better way. That's it".

Similarly for hospital Z, managers in general do not see the hospital as being well-organized. For example, one manager said:

"No, I don't see it as very well-organized. For improvement, I think we should have a manager that has a good education, knowledge, and background in hospital management to reduce costs and waste of money whenever present, and for sure to improve and increase the revenues".

Another manager said:

"I see there are problems in this hospital at the management level. Lately, I can say we are in a transition phase where things normally are not in their stable positions. But I expect that after this phase things will get better."

Based on the interpretations of the interviewees' answers, the efficiency appears to be highest in hospital Z, followed by a good efficiency in hospital Y, followed by a moderate efficiency in hospital X. As for the recommendations for a better efficiency in hospital X, these were very specific and important. Below are some quotations of recommendations by different managers in hospital X for the improvement of efficiency:

- "In order to improve the efficiency, there should be a more homogeneous management. It should be able to stop the corruption, the waste, and squandering of money, and specify more accurately the exact roles and requirements of each of the managers because the roles are overlapping in this hospital."
- "It could be improved through new trainings to the employees, new motivation methods, and new methods of perspectives for the employees to know where they are heading in the future concerning the promotions, etc..."
- "We should work on the redistribution of employees, and on giving priorities to the profit centers (departments) which are known at this hospital and make larger profits than those that we name as cost centers (departments) which sometimes have expenses larger than revenues, and thus lead to certain losses."

So, as a summary, for a better efficiency at hospital X, a more homogeneous management was recommended, with a better specification of the exact roles of each manager. Better trainings of employees, better motivation techniques, and giving priorities to profit centres were also recommended.

5.2.4 Internal reporting systems at the hospitals

In answer to the question 'to whom does each of the managers report?', the reporting system at the managerial level seems to be homogeneous in terms of whom they are reporting to, as all interviewees answered with similar answers, reporting mainly to the president and to the management of the hospital they work for.

However, concerning the clarity of the reporting systems at each of the studied hospitals and the presence of problems in these systems, hospital X was described as having a clear reporting system. Any problem described pertained to its implementation, which relates to the issue of lack of timeliness and the fear of being penalized as a consequence of reporting mistakes. When asked if

the systems of reporting are clear at the hospital, one of hospital X's managers said: "Yes, it is always written on papers, but sometimes it is not implemented properly". Another manager said: "Yes, everything is documented". As for the problems with reporting, one of the managers said:

"Sometimes some people don't want to report since they are afraid to be penalized. But we are not dealing with the system of reporting for the purpose of penalizing; we are dealing with it for improvements, but they do not understand it that way".

Another manager said:

"The delay of response is the main problem with reporting. This leads to difficulties in taking action because of not having clear and documented answers from the person in charge".

In hospital Y, the reporting systems were described as being clear in some departments, and not clear in others. When asked if the systems of reporting are clear at the hospital, one of hospital Y's managers said:

"In some places no. And this is because of fear. We always clarify the case that whenever something is done inappropriately, we need to work on preventing its occurrence the next time. Here, sometimes mistakes are hidden, and these will by default be repeated another time -- as for the reporting between the clinicians and the management, there is a kind of control done by physicians because they act as if they have the power and control. This is because the system we have is not based on salaries; physicians have priorities. This is causing lots of problems in reporting".

Another manager said:

"Most of the times they meet in person, this is a major point that we are working on at this hospital- they do not respect the reporting system appropriately. They always try to solve problems orally. I think they are afraid of reporting as things will be documented. So this should be worked on".

As for the problems with reporting, one of the managers said:

"Lots of our physicians do not like to write and report; they do it verbally. Nowadays, we shouldn't have things done verbally- So we have a problem from this aspect".

Another manager said: "the written report shouldn't be considered as dangerous. This helps in better control".

On the other hand, in hospital Z, the reporting system was described as clear by one of the managers and unclear by the other. The reporting problems are focused on the physicians who do not report because of the power given to them and that is allowing them to overcome the set systems. One of hospital Z's managers said: "there are always problems with reporting -- I see that there will be solutions on the short term".

The fear of being penalized was not mentioned in hospital Z. It is also important to note that in hospital X, the power of physicians was not mentioned as a problem for reporting.

So as a comparison of the three hospitals, the reporting system in hospital X is clear, but the problem is with its implementation. On the other hand, hospitals Y and Z in general had an unclear reporting system. Therefore, the two main problems with reporting that the studied hospitals are facing are the fear of being penalized as a consequence of reporting mistakes (hospitals X & Y), and physicians not willing to report (probably caused by two contradictory accounts of reporting, and an issue of power relationships at the hospitals), preferring to take the easier step of doing it verbally (hospitals Y & Z).

5.2.5 Hospital Management Systems

Perceptions and opinions of the management systems at the hospitals can be described by combining answers from different questions already asked at the interviews. For example, in hospital X, a manager mentioned variable management and corruption and squandering of money at the hospital. He also mentioned a lack of role specificity and an overlap of roles for managers. Similarly, a manager at hospital X said that "the responsibilities of individuals should be better specified and implemented. Each individual should be more responsible in the field where he/she is". This infers that in hospital X, there is potentially a problem that role descriptions are not clear, and there is an overlap of responsibilities. On the other hand, a manager at hospital X said that "we should update our procedures to become more efficient" without specifying the main problem in the procedures; this only implies that certain procedures are not up to date.

In hospital Y, a manager said: "we need better regulations in some places" and "the head of the pyramid should control things in a better way" thus showing

that in this hospital, the “head of the pyramid” is not doing his job appropriately. In this instance it was clear that the interviewee was referring to the CEO.

In hospital Z, a manager said:

“I think we should have a manager that has a good education, knowledge, and background in hospital management to reduce costs and waste of money whenever present, and for sure to improve and increase the revenues”.

According to his perception of the background of the general manager, his statement implies that the general manager of this hospital may not have the adequate education, knowledge, and background for the position he is having. It also shows that there are big costs that could be reduced, and waste of money that could be prevented. The manager here may have also said this statement based on a comparison of the general manager of hospital Z to an ideal general manager. On the other hand, another manager at hospital Z said: “I see there are problems in this hospital at the management level. Lately, I can say we are in a transition phase where things normally are not in their stable positions”. His statement seems to refer to the CEO, describing the corporate governance event mentioned by many of the managers.

The reporting systems, being part of the managerial systems on the managerial level, seem to be homogeneous in terms of to whom they are reporting, as all interviewees answered with similar answers, reporting mainly to the president and to the management of the hospital they work for. But problems can be summarized by the difficulties and problems of the implementation of those systems. In hospitals X and Y, the fear of being penalized was a distinct issue. Moreover, in hospitals Y and Z, the power given to physicians was also a major issue in reporting. Both these issues lie under the responsibility of the management.

As for the incentives, because of the financial problems that caused monetary incentives to be put on hold, interviewees in all three hospitals stressed on minor social incentives that keep the employees incentivized to stay working at the hospitals, rather than the financial incentives that were put on hold due to reported bad management. For example, a manager at hospital Y stated that

“the good thing is the relationship at work; we focus on making this relationship as a good work relationship. At the same time, we have the concept of working as a family here. This is an important incentive that encourages employees to work at this hospital”.

In all three hospitals, the monetary incentives were present until 2016, but they became on hold due to the financially difficult period the hospitals are all passing through. Hospitals X and Y mentioned the CAPN program (Contrat d'activite negotiable) which gives incentives based on activity that they used to implement. This program was not mentioned by interviewees from hospital Z but bonuses related to performance specifically were mentioned. Incentives, according to the interviewees' answers in general, are mostly present in hospital Z, if we are to compare the three hospitals. This is based on the answer of a manager at hospital Z who reassures the presence of incentives at this hospital, although a contradiction comes from another manager of this same hospital, stating that the system of bonuses based on performance is now on hold. This shows some contradictions within the responses offered on hospital Z in this aspect, mainly based on different perception of the issue of incentives at that hospital. Because of the financial problems that caused monetary incentives to be put on hold, interviewees in all three hospitals stressed the significance of social incentives that keep the employees incentivized to stay working at the hospitals. For example, a manager at hospital X stated that

“There are few monetary incentives, some incentives related to the accommodation of the work time and vacations, social incentives like the mutual respect, the trainings, etc... but as I said there are no outstanding incentives.”

It was also concluded that, according to the interviewees' answers, in hospital X, incentives are mainly the same for all staff, while in hospital Y incentives are not the same for all staff. On the other hand, in hospital Z, there was no clear conclusion as answers of interviewees differed.

In hospital Y, staff may be generally paid better than hospitals X and Z, but in all cases, there was no strict answer proving a positive perception of the salaries, suggesting that all staff are being well-paid in any of the three hospitals.

Although the performance, efficiency, and degree of organisation of the hospitals reveal the clinical governance inside the hospitals, they are also a basic part reflecting the corporate governance at the hospitals.

In their accounts of how performance measurement operates at the three hospitals studied, interviewees appeared knowledgeable and confident of how such systems worked in hospitals X and Z but less so in hospital Y: in hospital X, the perception of their presence and the knowledge of their types and methods of implementation were shown to be favourable. On the other hand, in hospital Y, it was shown that there may be a lack in the knowledge and a possible lack in the implementation of the proper methods of performance measurement. Hospital Z was somehow similar in this case to hospital X in the performance measurement methods. Concerning the renewal of contracts, there was a clear contradiction and lack of knowledge on whether there are real contracts for all staff, and whether the contracts are renewed according to the performance of the individuals. Based on all the interviewees' answers, and putting the clear contradiction aside, we may say that whenever there are contracts, performance is taken into consideration for their renewal.

Based on the interpretations of the interviewees' answers, and based on their perception of efficiency, the efficiency seemed to be the highest in hospital Z, followed by a good efficiency in hospital Y, followed by a moderate efficiency in hospital X.

As answers on whether each of the three hospitals is well-organized, two managers in hospital X see it as not being well-organized, and one as well-organized with the need for improvements. As for hospital Y, managers in general do not see the hospital as being well-organized and a similar view was shared by managers in hospital Z, where managers in general do not see the hospital as being well-organized.

5.2.6 Relationship of clinicians with the management

In hospital X, some interviewees described the relationship between the management and the clinicians as good; some described it as very good, and

one manager mentioned a dilemma in the relationship caused by the physicians, considering that they are the ones bringing work to the hospital. He stated that “they consider that they are the ones bringing work to the hospital, while the management considers them as employees at the hospital”. This causes a problem in the relationship between the management and the physicians.

Moreover, the same problem mentioned in hospital X relevant to the power of physicians was raised, as said by a manager at hospital Y: “physicians act as if they have the power”. On the other hand, in hospital Y, the relationship between the management and the clinicians was described in general as good as there is a non-stop communication between the two parties. Additionally, the fact of the management needing to continuously ask clinicians to fill forms and reports negatively affects the relationship between the management and clinicians. In hospital Z, the relationship between the management and the clinicians was simply described as a good one and of having a close relationship between the mentioned parties.

5.2.7 Quality of care, clinical governance and critical realism

Critical realism reinforces the position that there is an objective reality but that people can experience this reality differently and their experiences are likely to be related to events they experience. In terms of quality of care, therefore, it is possible for a hospital to offer objectively poor clinical care but for patients to not experience care as poor. For example, patients may experience the hospital as providing good care if they are attended to by someone who demonstrates compassion and is effective at their role. This event forms part of what critical realists refer to as the ‘actual’ which touches on both ‘the real’ and ‘the empirical’. It is also possible, in ‘real’ terms, for care to be good one day but poor the next due to issues affecting the day-to-day work of the hospital, such as adequate staffing, materials, and equipment. Arguably, systems of clinical governance attempt to establish a foundation of good practice in spite of day-to-day contextual variations or events that disrupt the management of the organisation, sometimes as consequences of corporate governance. They instate mechanisms whereby good quality of care can be known and assessed independently of individual experiences. Without good clinical performance,

patients may choose not to use the hospital (where they have the choice) and staff may choose not to work there. This, in effect, would bring about a corporate governance failure.

In this example, there is also a spiritual mission, core to the ownership that emphasizes the patient experience of good care. This mission also holds implications for the 'type' of patient the hospital cares for based on their mission. As a manager at hospital Y said:

“University hospitals can earn more money, they can ask for larger amounts of money in return for their services; this is because they do not have a mission similar to ours. Our mission forces us to help lots of people”,

thus creating non-commercial motivations and underlying mechanisms.

5.2.8 Knowledge and experience

When asked about knowledge and experience of senior managers and members of the general council (board of directors), most interviewees focused their answers on the senior managers. Based on their answers on whether the senior managers have appropriate professional backgrounds and experience, it can be surmised that most of them have the appropriate professional backgrounds and experience.

The obvious issue that was deduced from their answers is their lack of knowledge of the members of the general council. Some have said that they rarely meet with the members of the general council (board of directors); some said that they do not know their professional backgrounds and experience, and some did not mention the general council in their answers at all although they were asked about them. An interesting quote here is for one of the managers of hospital Z who did not agree that all senior management and board members had appropriate professional backgrounds and experience. He said: “especially the members of the general council who may not even have some simple diplomas in this field”; another manager from hospital Y referred to the senior management only in that “in general all of them have at least a master degree”.

As a description of the education and knowledge of the general manager at hospital Z, a manager at the hospital stated that

“we should have a manager that has a good education, knowledge, and background in hospital management to reduce costs and waste of money whenever present, and for sure to improve and increase the revenues”.

According to his perception of the background of the general manager, his statement implies that the general manager of this hospital may not have the adequate education, knowledge, and background for the position he is having, thus proving his point on the appropriate professional backgrounds and experience.

Moreover, it can be interpreted from the answers of interviewees to a question on performance that in hospital Y, there may be a shortage of knowledge for those responsible for the implementation of the proper methods of performance measurement.

5.3 The significance of stakeholders to hospital governance

5.3.1 Patients

Patient satisfaction is directly related to the standard of care at the hospitals but as described above may diverge from actual standards of care. In hospital X for example, a manager referred to a perceived high level of patient satisfaction by relating it to the high occupancy rates at the hospital. He referred to the hospital as having “lots of loyal patients”, and “we are therefore fully loaded at most of the times”. As an answer to the level of efficiency at the hospital, a manager at hospital Y said: “we are not 100% efficient but we aim to follow up on patient satisfaction and we follow up on this as much as we can”, thus suggesting relationship between the efficiency of the hospital and patient satisfaction. Their statement also shows that patient satisfaction is being taken as a primary goal of hospital Y, since they said that they are following up on the patient satisfaction as much as they can. Moreover, the presence of the patient safety managers and patient safety departments at each of the three hospitals under study reflects a target set by the hospitals to reach maximum patient satisfaction. This shows that the hospitals are aware of the fact that patients are

their businesses' only customers and that they need to care for them well to ensure the continuity of their missions.

5.3.2 Other Stakeholders

To be commercially successful, hospitals need to perform and be governed well, both clinically and financially. Although corporate governance concerns financial governance, there is a clear relationship between the financial success of the hospital, its capacity to offer good clinical care, and its reputation with key stakeholders, specifically patients. These relationships, according to the critical realism approach, are described as the 'real'.

All interviewees of the three hospitals stated that some of their major tasks are related to external organisations and external requirements. Some of the external organisations mentioned were universities, pharmaceutical companies, the Order of Physicians, the Order of Nurses, the Order of Midwives, the Syndicate of Private Hospitals, the Ministry of Labour, the Ministry of Public Health, the Ministry of Finance, insurance companies, and the Social Security (NHS). It should be noted that the mentioned stakeholders are external stakeholders, and they exclude the internal stakeholders which are those with an interest or concern in the performance of the hospitals, including the clinicians and other employees.

As a summary of their descriptions of the requirements, lower-level personnel on the hierarchal structure deal mainly with internal requirements, while the governance and the upper-level managers deal with both internal, and external requirements represented by the requirements of external stakeholders.

5.3.3 Roles of External Stakeholders

The way that clinical governance and quality of care are described shows that as systems they are tied into professional bodies and frameworks of standards operating at a national level. These are external stakeholder organisations and governance systems that are, through both mechanism and experience, directly linked to the internal management systems of the hospitals via: the medical committee structure, human resource processes concerning staff training, professional development, and evaluation; through local projects to implement national standards and initiatives. As previously mentioned, external

stakeholders, being the stakeholders not internally involved in the daily performance and functioning of the hospitals, include the universities, pharmaceutical companies, the Order of Physicians, the Order of Nurses, the Order of Midwives, the Syndicate of Private Hospitals, the Ministry of Labour, the Ministry of Public Health, the Ministry of Finance, the insurance companies, and the National Social Security (similar to NHS in England). The roles of these stakeholders and their relationship with the hospitals are external factors that directly affect the internal performance of the hospitals. Each of the different external stakeholders affects the hospitals differently. Some universities for example send medical and nursing students to do some training at the hospitals which requires preparation and adaptation to clinical strategies. Pharmaceutical companies supply the hospitals with medications and certain medical equipment, hence they are one of the most essential stakeholders affecting the performance and functioning of the hospitals. The Order of Physicians takes the role of the protector of the physicians' rights; moreover, it assists the hospitals in providing certain training for the physicians and managers of the hospitals. The Orders of Nurses and Midwives on the other hand do similar jobs as that of the Order of Physicians, but at the level of nurses and midwives respectively. The Syndicate of Private Hospitals protects the rights of the private hospitals, both the for-profit and non-profit ones. The Ministry of Labour works on protecting the rights and specifying the duties of all employees of the hospitals towards both the hospitals and the government. The Ministry of Finance's relationship with hospitals mainly lies in the official presentations of the financial statements and the accounting results for the purpose of keeping track of the hospitals' financial situations, and for setting taxes whenever required. Insurance companies support hospitals through providing them with financial returns on behalf of insured patients. Last but not least, the National Social Security works on protecting the rights of employees towards getting medical support from the National Social Security office.

An example referring to the effect of the external factors on internal performance lies in the statement of a manager at hospital Y:

“We have some problems with our hospitals, sometimes caused by the lack of funding from the government, the money we already need from the government.”

In many ways, this stakeholder involvement stabilizes and improves clinical practice, systems, and overall governance at hospital level because it includes relationships, organisations, and mechanisms that are independent from the corporate governance of a hospital or group of hospitals.

5.3.4 External stakeholders and critical realism

What becomes clear is that not all corporate governance mechanisms are located within the boundary of the organisation or organisational structure. Particularly in the case of hospital governance, mechanisms relevant to quality of care, professional standards, and compliance with national government legislation cross the boundary of the hospitals. These mechanisms are key to ensuring that the hospitals maintain relationships with patients and with professional standards of care. These mechanisms are experienced as relationships that remain consistently important and are in contrast with events, known in critical realism as ‘the actual’, which are discussed next.

5.4 Corporate governance events

An interesting feature of this research is that during the course of fieldwork the CEO left the organisation. As a researcher at the organisation it was difficult to find out about the circumstances in which the CEO left. There was an unwillingness to speak about this event but there was nonetheless a sense that there was some controversy surrounding his departure. Clearly the departure of a CEO raises important questions concerning corporate governance but from a research point of view it creates a paradox whereby the details of this sensitive situation are hard to ascertain. In this section the departure of the CEO to the extent that it is discussed by interviewees is explored.

5.4.1 Perceptions of CEO power

When talking about control at the three hospitals, a manager at hospital Y mentioned that, according to his knowledge, the financial control of the three hospitals is in the hands of the general management of the three hospitals represented by the CEO. Moreover, another manager at the same hospital also mentioned that control in terms of power at the three hospitals is in the hands of the CEO, among others. He said: “Power is in the hands of the CEO, the

hospital's manager, and the president of the hospital". These examples show that quite a high degree of power is attributed to the CEO of the three hospitals.

5.4.2 Conflict of interest

When asked whether the CEO can prioritize his personal interests over the interests of the hospital, 5 out of 8 interviewees tried to avoid or refused to directly answer the question. Of those who gave answers, a manager at hospital X indirectly referred to the CEO and said: "in fact I am surprised by what happened; we all are, and we are sad about it" and "I don't know here if the CEO was really able to do whatever he wants without control, or whether other people are involved". Here, this manager indicated a possible case of conflict of interest, indirectly implicating the CEO, and other unspecified people. Other interviewees said that everyone can prioritize their personal interests if they want to, but they should not. In order to prevent it from occurring, another manager at hospital X said that "there should be a reliable board that controls all the goals and that has its own accountability". A third manager at hospital X said that "the general council must have good control over the CEO – the CEO should not have the total power over everything without communicating and taking instructions from the general council"; this is how she describes the methods of preventing the CEO from prioritizing his personal interests. Moreover, it was clear that in hospital Y, all interviewees were trying to avoid answering the question on conflicts of interest. One manager said: "I don't have a direct relationship with the CEO, so I cannot answer such question". On the other hand, another manager answered by "may I skip this question?". Likewise, a third manager said: "I am not really involved in the system from this aspect". A manager at hospital Z was critical of hospital systems, saying: "in these hospitals, the CEO can easily prioritize his personal interests over the interests of the hospital due to the system overall". By system, he is most probably referring to corporate governance, and hence indirectly describing the corporate governance of the hospitals as poor.

Based on all the interviews, it was clear that there is a lack of information related to the cause of the CEO's sudden leaving of the hospitals. As described by one of the managers of hospital X,

“what happened in fact is that the CEO left the hospital due to problems that happened with him. He was replaced by a committee constituted from different people and professionals. This committee is now responsible for the management of the hospital.”

And when asked to describe the causes that led the CEO to leave, he said that

“the congregation found that it is losing financially rather than improving as it was planned, so the general council decided to change the CEO. The debt has exponentially increased. They told him that you did not succeed in your job, so you have to leave. That’s what I know; I am not deeply involved, and I do not know all the details.”

This manager was also asked if he describes this case as a conflict of interest, his answer was: “I am not really involved in the details, but I think yes.”

Therefore, all the above may reflect a case of conflicts of interest, but no real proofs are available for that. As noticed from most of the interviews, this is a sensitive topic that either led the interviewees to try not to answer the questions related to it, or revealed that they really did not know its details.

The CEO, being one of the stakeholders having a stake in the hospitals’ success, had to leave his position due to unclear reasons. The CEO leaving is an actual event that, to some extent, makes the mechanisms of corporate governance visible. Empirically, interviewees referred to this event in different ways. Some interviewees mentioned the crisis that the hospitals are passing through. A manager at hospital Y for instance, mentioned that “we are passing through a crisis”. Others referred to his leaving by indirectly stating their opinion of its causes. As an answer to a question on the recommendations for a better organisation of the hospitals, a manager at hospital Y said that “the head of the pyramid should control things in a good way. That’s it”.

As previously mentioned, most of the interviewees felt that the topic of the CEO leaving and its causes is a sensitive topic that they had the tendency/preference not to refer to with ease. The clearest reference is a manager at hospital Y who answered by “may I skip this question?” when asked if the CEO can prioritize his personal interests over the interests of the hospital.

Based on background information collected from unrecorded meetings with two of the presidents of the hospitals and with the CEO himself throughout the preparations of the interviews, it was obvious that power is given to the CEO in

nearly most of the aspects. This was also shown through the answers of the interviewees and the results that most of them were surprised of. Financial problems suddenly appeared as a result of the mismanagement of the CEO, uncontrolled by most of those who have the rights to control his acts and management decisions. When asked about recommendations for better performance of the hospital, a manager at hospital X said

“in order to improve efficiency, there should be a more homogeneous management. It should be able to stop the corruption, waste, and squandering of money, and specify more accurately the exact roles and requirements of each of the managers, because the roles are overlapping in this hospital”.

And when asked if this is a cause of the problem that has happened with the CEO, he said “yes”.

The fact that most interviewees were surprised by the sudden financial problems and the departure of the CEO raises important questions. As previously mentioned, interview questions on the CEO issue appeared to be sensitive. Interviewee sensitivity is by itself an interesting topic. The reasons for them to be sensitive may be because they could be protecting the interests of the hospital. They could also be concerned that what they say is held against them by hospital managers (even though confidentiality was guaranteed). This made investigations in this aspect to be quite difficult. A corporate governance event of this kind raises people’s awareness of corporate governance mechanisms and structures, and changes people’s perceptions and knowledge of it.

5.4.3 Corporate governance events and critical realism

According to critical realism, events are a key aspect of how understanding of real, causal mechanisms begins and changes as a result of experience. The departure of the CEO prompted managers to engage with and think about corporate governance of the hospitals differently. It focused attention on the over-arching governance structures that apply to all three hospitals and on the shared financial management structures. It also focused attention on what, from the interviewees’ point of view, constitutes ‘good’ and ‘bad’ governance based on their own judgment of how high level responsibilities should be executed.

The following chapter discusses the questions raised in the previous chapters, with a detailed discussion of the quantitative and qualitative data analysis.

Chapter 6

DISCUSSION

As existing research shows, hospital governance requires a broader discussion of corporate governance than one based on principals and agents (Mayer, 2013; Zeckhauser and Pratt, 1985; Jones, 2010; Claessens and Yurtoglu, 2012; Shleifer and Vishny, 1997). The relationship between owners and managers remains important, and ensuring managers are accountable for their actions remains a key function of hospital corporate governance. However, other relationships are also important, including the relationship of corporate governance to clinical governance frameworks and relationships with key stakeholder groups.

In an interview with Roy Bhaskar (Faculti, 2014), he said that “you couldn’t reduce statements about the world (which is ontology) to statements about our knowledge of the world (which is epistemology)”. Our knowledge of the world can sometimes be referred to as the perception of the world. So in this part of the research study, the perception of hospital governance is an epistemological measurement relative to the real world. Alister McGrath (Oxford Conversations, 2016) referred to Bhaskar’s critical realism in an interview by saying that “ontology determines epistemology; the way things are affects the way which we know them, and the extent to which they can be known”. It can be interpreted that the way things are refers to the ‘real’; the way in which we know them refers to the ‘actual’; and the extent to which they can be known refers to the ‘empirical’.

First and foremost, this study created and tested a tool for measuring hospital employee perceptions of governance according to managers, clinicians, and members of the Board of Directors. Factor analysis evidenced which items best combined to construct an overarching concept of governance. Using the final selected questionnaire items, the tool has been tested and has been proven to be successful in the context of three hospitals in identifying whether or not an overarching concept of corporate governance can be said to exist. The tool measured respondents’ perception of both corporate and clinical governance and confirmed the importance of the relationship between them. The relationships between corporate and clinical governance were tested for

through the analysis of the main hospital governance concepts that were covered in this research. Stakeholder relationships with external organisations were also confirmed as being highly significant through their capacity to work across and draw together clinical and corporate governance concerns. In addition, the qualitative interviews identified 'corporate governance events' as phenomena that change people's perception of corporate governance, leading them to see the implications and consequences of corporate governance differently and perhaps more clearly. This chapter begins by considering the implications of producing a tool for measuring perceptions of hospital corporate governance more closely.

6.1 Perception of hospital governance

Corporate governance structures provide the owners of organisations with mechanisms through which they can make managers, and particularly senior managers, accountable. In this research, the perception and understanding of these mechanisms were demonstrated by using questionnaire items to represent the mechanisms identified by existing research as likely to be most clearly visible to respondents. The items included ones related to clinical governance, external stakeholders, performance management, control and power, among others (see appendix for a full list). While the scores on individual items correlated to demonstrate that a stable and overarching concept of corporate governance can exist in the hospital setting, the total perception of governance scores also illustrated variation in individuals' perceptions.

Results varied according to differences in the hospital where the respondents work, their current role at the hospital, their managerial role, their management experience, their management education, leadership role, and the number of years that they have been working for at the hospital. Some other variables like age and gender had no significant effect on the difference in perception of the respondents to hospitals' governance. While respondents to the questionnaires were clinicians (physicians and licensed nurses), managers (clinical and non-clinical), and members of the board of directors, the small sample of qualitative interviewees were all managers (clinical and non-clinical). To understand variations further, the section below discusses the interviews responses in order

to support explanation of how position within the organisation influences perception of corporate governance.

When asked about the tasks each of the interviewees are involved in, most of their answers reflected precise knowledge of their specific tasks and duties, reflecting good knowledge of local systems of governance and management. However, knowledge of governance mechanisms and structures beyond the local setting was very different.

The congregation as a whole has a board of directors whose role is to oversee the functioning of the hospitals it owns. The board is described as the 'general council' and constitutes of five nuns. There were different perceptions of the Board of Directors' presence and role. For example, reporting was described as mainly internal (i.e. occurring within the organisational boundaries of each hospital): to the presidents of the hospitals, to the general management, to the human resources manager, to the medical committee, and to the CEO. None of the interviewees mentioned that they report to the Board of Directors (in this case the General Council), or that any reporting of any type is submitted to the Board of Directors.

Interestingly, the importance of the general council and its significance to management and clinical governance systems within the three hospitals was rarely mentioned by interviewees. Some managers used the term 'board' to refer to the medical committees at each hospital comprised of senior managers of each hospital. A manager at hospital X even speculated that "there should be a reliable board that controls all the goals and that has its own accountability" revealing how distant the board of the three hospitals could appear to managers. One example where the board of directors was mentioned comes from a manager at hospital Z who spoke of the board as being the primary source of power and control. He said: "in terms of power, the control is in the hands of the head of the general council, which is comprised of nuns". In general, however, perception of the Board of Directors as holding power or control over the organisation was not in evidence, most probably due to an absence of visible effect and involvement in the day-to-day functioning of the hospitals. Composition and function of the Board of Directors is a major

component of the corporate governance literature (Baysinger and Butler, 1985; Charitou and Soteriou, 2017; Olson and Wright, 2015). However, it is mainly discussed in relation to for-profit corporations, and hospital governance authors have argued that particularly in the case of non-profit hospitals a change in emphasis is required. Jamali et al. (2010) and Eeckloo (2004 and 2007) describe how the study of hospital corporate governance requires a shift in focus in order to acknowledge the significance of corporate social responsibility (CSR) and clinical governance. In many senses they are arguing that a different approach to traditional principal-agent and stakeholder questions is required in the case of hospitals and their governance.

As an example of how local governance arrangements were more readily discussed than the Board of Directors, a manager at hospital X and a manager at hospital Z mentioned that they are members of the Board of Directors, while they meant in fact that they are members of the medical committees of their corresponding hospitals. As a manager at hospital X stated: "I report directly to the Board of Directors of the hospital, as I am also a member of this Board". Through searching the website of the congregation that the hospitals correspond to and through unofficial interviews with the presidents of two of the three hospitals, it was assured that the General Council (being the Board of Directors and having its roles and duties) is constituted of women only who are all nuns. Hence, there is a general misuse of the term 'Board of Directors' and a clear tendency to describe local governance arrangements over corporate governance arrangements.

Based on the answers of interviewees, there appears to be a good standard of knowledge and experience on the level of senior managers at the three hospitals. Most of the interviewees agreed that the level of knowledge and experience of senior managers at their hospitals is good. A manager at hospital Y for example referred to the senior management in his hospital by stating that "in general all of them have at least a master degree", while exceptions appear in a manager of hospital Z's statement in referring to the general manager of this hospital by indirectly saying that the general manager of the hospital does not have a good education and knowledge.

According to the answers of respondents to the questionnaires, the answers to a statement that asks if the CEO has an appropriate professional background were as follows: the average result of hospital X was 2.31; that of hospital Y was 2.69; and that of hospital Z was 2.28, with an average result of 2.38 for all three hospitals (ANOVA: $F=3.34$, $df=2$, $p=0.037$). Since the standard deviation is 0.89, this shows that most respondents tend to agree with the statement overall. This shows an overall result that, according to the perceptions of the respondents, the CEO has an appropriate professional background, thus supporting the fact that the corporate governance problem which resulted in the hospitals is caused by a corporate governance failure rather than by lack of knowledge and professional background.

When asked about the knowledge and experience of the members of the general council, most interviewees didn't give clear answers. This is most probably caused by the lack of knowledge of the interviewees concerning the members of the general council, or by unwillingness to say bad things about the members of this council.

According to the answers of respondents to the questionnaires, the answers to a statement that asks if the members of the general council have appropriate professional backgrounds were as follows: the average result of hospital X was 2.5; that of hospital Y was 2.9; and that of hospital Z was 2.51, with an average result of 2.58 for all three hospitals (ANOVA: $F=3.34$, $df=2$, $p=0.037$). Since the standard deviation is 0.91, this shows that most respondents working in hospitals X and Z tend to agree with the statement overall. The respondents' answers somehow contradict with the answers of many of the interviewees who did not agree that the members of the general council have appropriate professional backgrounds. As previously mentioned, both the answers of the respondents to the questionnaire and those of the interviewees may be biased by the fact of the lack of knowledge of the members of the general council, and even sometimes by the lack of knowledge of the presence of the council.

In many cases, perception of hospital governance was shown through the precision of the answers given by most interviewees to most of the questions.

Each of them was highly knowledgeable of the overall system in which the hospitals function. They are aware of their own tasks and responsibilities. They described their responsibilities in detail and offered their opinions on the efficiency of the organisation. They were aware of issues associated with clinical reporting, patient safety, resourcing, and management systems, and they were able to provide suggestions for resolutions. They were also able to describe the methods of performance measurement used, and suggest methods for the improvement of performance at their hospitals. They were aware of the external stakeholders to which the hospitals are accountable. They were also aware of clinical governance systems and standards of safety and quality at the hospitals.

Despite an absence of reference to the Board of Directors, one issue that most interviewees were aware of was the corporate governance event that took place in the hospitals related to the resignation of the CEO. Most of the interviewees referred to this event in one way or another. The majority referred to it through linking it to the financial problems/ crisis that the hospitals are passing through. Section 6.4 discusses this finding further.

When asked about the methods of performance measurement used at the hospitals, all interviewees seemed to have a perception of systems that was consistent with the systems in place. Clear methods of performance measurement were in use at each of the three hospitals. Some methods were common across the hospitals and some were unique to each hospital. The full list of performance measurement methods used in each hospital is presented in the qualitative analysis chapter.

Although employment contracts are often linked to individuals' performance, the answers of interviewees reflected a degree of confusion in this respect. There were also differences in the descriptions given of contracts and their renewal based on performance. In this example, most of the interviewees had opposing answers. There was a range of opinion as to whether there are formal contracts in place for everyone at the hospitals. Many said that there were no formal contracts; some referred specifically to physicians stating that they do not work based on contracts. Others answered that whenever there are contracts, performance is taken into consideration for their renewal. Answers also differed regarding whether all staff are well-paid at the hospitals. There appeared a

divergence of opinion on this question as no clear answers were given by interviewees. Some answered with a 'yes' but could not support their ideas, and others answered with a 'no' but were not sure about their answers.

Responses to the survey showed the average degree of agreement to the statement 'all hospital managers should have fixed-term employment contracts which are reviewed and renewed against their performance' was 1.83 on a likert scale of 5. The 1.83 average score falls between 'strongly agree' and 'agree' responses with a slightly increased tendency to 'agree', thus showing an overall agreement with the idea that all hospital managers should have fixed-term employment contracts which should be reviewed and renewed against their performance. Comparing the means of the three hospitals for the same question, the average result of hospital X was 1.8; that of hospital Y was 1.86; and that of hospital Z was 1.85. This shows that on average, all respondents at the three hospitals had almost the same overall opinion regarding this act (ANOVA: $F=0.134$, $df=2$, $p=0.875$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the independent variables, but since its standard deviation is 0.78, this shows that most respondents tend to agree with the statement overall. Moreover, this question was not one of the 16 retained for the overall factor scores of respondents' perception of hospital governance and scores on this question do not correlate strongly with the factor scores. It nevertheless shows the level of agreement between staff to the question of contract renewal and its link to performance.

With respect to problems in hospital management systems identified by interviewees, these were described by interviewees at hospital X as being: overall lack of consistent management; corruption including waste and 'squandering' of money; the roles and requirements of managers are not accurately specified, with an overlap of roles; and out-dated managerial procedures which are not focused on efficiency. Based on the declaration of interviewees in hospital Y, the hospital needs better regulations, and more effective management from what they called the 'head of the pyramid' referring to the general council. Similarly, based on interviewee responses in hospital Z, inadequate education, knowledge, and background in hospital management can

affect the efficiency of the hospital, resulting in waste of money and increase in costs, leading to decreases in revenues. In some cases, this was attributed by managers to a specific period of change the hospital was experiencing in which the organisation is not as stable as it could be.

Interviewees speculated that corporate governance failure had brought about a financial crisis in the hospitals, due to which major incentives that were present until 2016 were put on hold. This absence of monetary and other incentives may directly affect the performance of the employees and as a result, could be seen as negatively affecting the overall performance of the hospitals. As clinicians are a core component of hospitals, anything that has the potential to directly affect their performance, directly affects the mission of any hospital, which is to provide good care. This is not to say that incentivisation acts in a purely mechanistic way. Clinician professional values may mean that their clinical practice and the quality of care they provide is unaffected by incentivisation mechanisms. However, it may have implications for staff satisfaction and retention.

As for the strategic vision of the congregation, their vision seems to be confidential, and this is not normal in a sound corporate governance system where strategic visions are open to the public, and are used as a method of describing the visions of the organisations to external stakeholders.

In terms of hierarchical structure, it was clear throughout the study that the hierarchical structure of the hospitals, although properly set, was not part of the direct experience and hence perception of governance held by the majority of employees and managers. Most interviewees adequately described the internal structure of the hospitals they work in, but none of them extended their descriptions higher into the hierarchy to mention the general council. This shows that interviewees are indirectly not giving importance to the role of the general council, or they are not aware of its presence or role. The hierarchical structures of the studied hospitals reflect a good governance structure, irrespective of whether the structure is respected in terms of its role and the implementation of proper corporate governance strategies, as good

management needs much more than just a structure (Rodan and Galunic, 2004; Provan and Kenis, 2008).

Where the general council was mentioned, findings from both qualitative and quantitative data point to the particular significance of the relationship between the general council and the CEO. A manager at hospital X stated that

“the general council must have good control over the CEO - the CEO should not have the total power over everything without communicating and taking instructions from the general council”.

This shows an awareness of the agency problem and the need to ‘manage the managers’ which forms part of organisational members’ perceptions of governance. Answers to the questionnaire on a statement that checks whether the hospital's general council should have control over the activities of all hospital managers also confirm that respondents perceive a need for the hospital's general council to have control over the activities of all hospital managers. The average result of hospital X was 1.85; that of hospital Y was 2.21; and that of hospital Z was 1.92, with an average result of 1.94 for all three hospitals (ANOVA: $F=2.8$, $df=2$, $p=0.063$). This low average result shows that many respondents agreed with the idea that the general council should have control over the activities of all hospital managers, while for the hospitals studied, the interviews showed this was perceived not to be the case. This statement item did not correlate with other opinions on governance, so it was not included in the overall measure of perceptions of hospital governance. It, nevertheless, shows that staff have a perception of how the council should function. Moreover, the one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the independent variables, but since its standard deviation is 0.86, this shows that most respondents agree with the statement overall.

In another statement that asks whether there should be more control over how the chief executive officer (CEO) spends the hospital's money, the average result of hospital X was 2.19; that of hospital Y was 2.67; and that of hospital Z was 2.25, with an average result of 2.3 for all three hospitals (ANOVA: $F=4.63$, $df=2$, $p=0.01$). This shows that the largest agreement to this statement came from respondents of hospital X, thus supporting the latter statement of the

manager of this same hospital (above). This also shows that most of the respondents perceive a lack of control by the general council over the CEO.

Managers had different perceptions of who held power over whom within their organisation, and to whom the control in different areas is given. Interviewees in hospitals X and Y described physicians in these two hospitals as holding considerable power. According to the answers of respondents to the questionnaires, answers to a statement that asks whether the CEO in this hospital has more power than the general council were as follows: the average result of hospital X was 3.11; that of hospital Y was 3.07; and that of hospital Z was 2.56, with an average result of 2.94 for all three hospitals (ANOVA: $F=5.86$, $df=2$, $p=0.003$). This divergence supports the answers of the interviewees who described a lack of clarity around the issue of power. It also shows that, according to the perceptions of respondents to the questionnaire, respondents from hospital Z agree to a larger extent than hospitals Y and X respectively, that the CEO has more power than the general council. This question was not one of the 16 retained for the overall factor scores of respondents' perception of hospital governance and scores of this question do not correlate strongly with the factor scores. It, nevertheless, shows the perceptions of staff regarding the degree of power held by the CEO in comparison with the general council.

Similarly, according to the answers of respondents to the questionnaires, answers to a statement that asks whether the general council has the power to direct the CEO to act in exceptional circumstances if they see it is for the hospital's benefit, responses were as follows: the average result of hospital X was 2.26; that of hospital Y was 2.52; and that of hospital Z was 2.15, with an average result of 2.28 for all three hospitals (ANOVA: $F=2.63$, $df=2$, $p=0.075$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the independent variables, but since its standard deviation is 0.83, this shows that most respondents tend to agree with the statement overall. This diversity of opinion over where control and power are situated could be due to the complexity inherent in these concepts or because, as with perceptions of corporate governance, people's sense of control and power vary according to when they are asked these questions and what their position is within the organisation.

Concerning the degree of organisation, the quality of care is directly influenced by the degree of organisation of the hospitals. According to the interviewees' answers on the degree of organisation, a lack of organisation appears to be present in each of the three studied hospitals. Two managers in hospital X see the hospital as not being well-organized, and one as being well-organized with the need for improvements. Managers in general at hospital Y do not see the hospital as being well-organized. Similarly, managers of hospital Z do not see the hospital as being well-organized. Here, it is noteworthy to refer to the 'Hospital name independent variable' section of the quantitative data analysis chapter, where the graph shows the most consistent perception (lowest factor score) of the overall hospital governance scores are in hospital Z, and those scores are significantly higher than in hospitals Y and X.

The same recommendations of increasing the efficiency were suggested by interviewees of hospital X for a better organisation of the hospital, adding the need for an increase in efficiency and better specifying and implementing the responsibilities of each individual. On the other hand, the recommendations of managers of hospital Y for a better organisation at the hospital were the need for better regulation and "the head of the pyramid should control things in a better way". As for hospital Z, the recommendations for a better organisation were related to choosing a general manager that has a better education, knowledge, and background in hospital management in order to reduce costs and waste of money whenever present, and to improve and increase revenues.

The statement of one of hospital Y's managers: "the head of the pyramid should control things in a better way" directly refers to a perceived lack of control exerted or used by the 'head of the pyramid' which is, in the case of these hospitals, the general council. Here, the manager is also referring to a perception of corporate governance which locates control over managers and management systems with the general council. On the other hand, the recommendations of hospital Y's managers clearly specify that the general manager of hospital Y, according to the interviewee's knowledge, does not have the appropriate education, knowledge, and background in hospital management, and are stating that there is a waste of money at this hospital, and that costs are high.

Based on the answers of interviewees, the expectation that the efficiency is highest in hospital Z, followed by a good efficiency in hospital Y, followed by a moderate efficiency in hospital X, comes in line with the answers of respondents to the survey on the governance at the hospitals. The average degree of agreement to a statement that checks whether the hospital is well-organized and efficient is 2.72 for hospital X, 2.67 for hospital Y, and 2.52 for hospital Z, on a likert scale of 1-5, where the mean of the three hospitals for the same statement was 2.65 (ANOVA: $F=0.665$, $df=2$, $p=0.52$). For this statement, it is remarkable to note that the one way ANOVA for this specific statement alone does not find the differences statistically significant. However, in terms of the extent of agreement, these results do not directly come in line with the answers of the managers that were interviewed, as based on the interviews, it was interpreted that all three hospitals are not well-organized.

In hospital Y, awareness of who was ultimately responsible for quality and safety was also described in terms of local systems. For example, a manager referred to “a committee responsible for quality and safety” while two other managers referred to two managers/directors; one responsible for quality and the other for safety. Similarly, the same responsibilities in hospital Z were described by a manager as a “council consisting of a manager, the head of the medical committee, a nun, and a priest”. Another manager at the same hospital referred to “a manager responsible for safety and security of patients. There is also one responsible for quality”.

In hospital Z, there were different descriptions of the clinical reporting system. A manager described the reporting system at the hospital as clear, whilst another said that it was not well-defined. Moreover, there was a difference of opinion on the quality of clinical reporting. For example, when asked whether there were any problems with reporting. A manager at hospital X said that “in 90% of the cases we have no problems”, and another manager at hospital Y answered with a “no”, while all other interviewees assured that there were problems with clinical reporting and described it in detail.

In terms of control at the hospitals, questions were divided into four categories: financial control; power; decision-making; and political control. Table 6.1 below shows the responses of interviewees to the qualitative interview questions on control.

Type of Control	People in control
Financial	<ul style="list-style-type: none"> • The new committee who took the place of the CEO after he had to leave • The President of the hospital • The Financial Manager of the hospital • The General Management of the three hospitals (headed by the CEO) • The financial management of the hospital • The Executive Director • The Chief Financial Officer (CFO) responsible for the financial performance of the three hospitals • The nuns
Power	<ul style="list-style-type: none"> • The new committee taking the place of the CEO after he had to leave • The President of the hospital • The Management Committee • Each of the Managers in their own department • The CEO and the General Manager of the hospital • The Head (chairman) of the General Council • The nuns • The physicians
Decision making	<ul style="list-style-type: none"> • The new committee taking the place of the CEO after he had to leave • Each manager in their own department • The president of the hospital • The financial manager • The management committee
Political control	<ul style="list-style-type: none"> • The new committee taking the place of the CEO after he had to leave • The nuns being the owners • The president of the hospital • The congregation in general • The management • Strong and well-known physicians of the country • Strong religious authorities • “Bkerke” (the center of the Maronite Catholic Patriarchate)

Table 6.1. Responses to qualitative interview questions on control

There was a particular instability around this knowledge which in some cases was linked to the current situation of the hospitals. For example, one manager said, “I do not really know during this phase who is in control financially”. All of these answers demonstrate there is a diversity of knowledge in relation to control, proving that interviewees had diverse perceptions of control at each of the three hospitals.

Moreover, there was a diversity of opinions concerning who is responsible for the financial performance at each of the hospitals. Answers of interviewees in the same hospital were different. In hospital X, for example, a manager referred to the committee replacing the CEO to be responsible for the financial performance, while another manager referred to the president of the hospital, and another manager referred to the financial manager. Similarly, in hospital Y, a manager referred to the financial manager, another manager referred to the CFO (Chief Financial Officer), and another manager referred to the executive director. Likewise, in hospital Z, a manager referred to the general manager, and another manager referred to the executive director. There was a diversity of opinion regarding who is responsible for the financial performance in each of the three hospitals, while there is a clear financial crisis at the hospitals. Whenever there are no clear set responsibilities as in this case, neither malfunctioning and financial losses may be easily detected, nor can responsibilities be specified.

Both the qualitative and quantitative evidence produced by this study show that knowledge of hospital corporate governance is ‘dynamic’, meaning that it changes over time, and according to both physical location and position within the organisation. It also varies according to individual experience and significant events of which people may or may not be aware. A major finding of this thesis is that in spite of this diversity, a stable perception of hospital governance does exist and can be measured. The following section shows statistical evidence of a single factor score of combined perceptions of hospital governance.

6.1.1 Age and Gender

When studying the relationship between demographic variables and factor scores, the results section showed both a consistent overall measure of perceptions of governance, as demonstrated by the single factor scores, but also differences within these perceptions. Statistical evidence showed that perceptions of governance did not differ by age or gender.

6.1.2 Current role at the hospital

One of the significant areas of association with differences in perceptions of governance was the current role of the respondent at the hospital. For the current role at the hospital independent variable, as shown in figure 4.2 of the quantitative analysis chapter, members of the board of directors showed lower factor scores than clinicians, namely physicians and licensed nurses, and licensed nurses had the highest factor scores (least consistent least consistent perception of hospital governance). This can be interpreted to be logical since the members of the board of directors are more involved in the overall governance of the hospital than clinicians who are more involved in the technical medical functioning. This explains why they have a more positive outlook towards their perception of governance.

6.1.3 Hospitals studied

It can be obviously seen in figure 4.3 of the quantitative analysis chapter that the factor score of members of hospital Z were far lower from those of the other two hospitals, thus showing a more positive perception of hospital governance than the other two hospitals. Based on the common significance of factor score, members of hospital Z had the most consistent perception of hospital governance, followed by hospital X and then hospital Y. Potentially, as a consequence, hospital governance at hospital Z is perceived more positively than in hospital X, which is perceived by itself better than in hospital Y. This may be also indirectly observed in the answers of the interviewees. For example, based on the interpretations of the interviewees' answers, the efficiency is highest in hospital Z. This was also proven in the respondents' answers on the survey statement that asks whether the hospital is well-organized and efficient, where respondents of hospital Z showed the largest

degree of agreement in comparison to the other hospitals. Another example lies in that only a manager at hospital Z referred to the general council in his answers, while all other managers did not. Similarly, as shown in the analysis of the quantitative data, the Lebanese Order of Physicians is perceived to represent the physicians' interests better in hospital Z, than in hospitals Y and X; and the Syndicate of Hospitals is perceived by respondents to pay more attention to achieving benefits for the owners of hospital Z, than those of hospitals Y and X. It is to be noted here that, based on the definition of the term 'perception', the hospitals that have the most positive and stable perception of hospital governance overall may not be the ones with the best hospital governance, as perception is strictly based on the knowledge and standpoint of the respondents; it is affected by place, position, and the degree to which knowledge about hospital governance is accessible to respondents.

6.1.4 Managerial role

Concerning the managerial role at the hospital independent variable, and as shown in figure 4.4 of the quantitative analysis chapter, it can be seen that those having managerial roles of 4/10 and 10/10, had the lowest factor score, and hence the most stable perception of hospital governance overall. Those with the highest managerial roles seemed to share a consistent and broadly accurate perception of hospital governance. This is possibly due to their dealing directly with the governance systems at the hospitals. Those with a 4 score also had a consistent perception of hospital governance, maybe due to their knowledge of the governance system without their direct involvement in it. 6 out of the 207 respondents had a managerial role of 4. Out of these, 2 were licensed nurses, 1 was a clinical manager, and 3 were physicians. These constitute only of 2.9% of the respondents, and hence may not be significantly taken into consideration when analysing the fluctuations of the graph.

Another interesting finding was the extremity of the score 1 for managerial role of 23 respondents. These respondents who constitute 11.1 % showed the highest factor score corresponding to the least consistent perception of hospital governance. Moreover, those having a management role of 6/10 and above had higher perceptions (lower factor scores) of hospital governance than those with management roles of 1, 2, 3, and 5.

The fluctuations of the curvature of the graph, not being linear with increasing perception (decreasing factor scores), may be related to the fact that the direct relationship between the degree of management role and the perception of hospital governance is affected by those managers who are non-clinical and are not directly involved in the governance system, rather than being involved with technical clinical professions.

6.1.5 Management experience

Concerning the management experience at the hospital independent variable, and as shown in figure 4.5 of the quantitative analysis chapter, it can be seen that those having managerial experience of 6, 7, 8, and 10 had the most consistent perception (lowest factor scores) of hospital governance. This is logical as those with high managerial experience have a larger tendency to be involved in governance practices than those with low managerial experience. Moreover, those having no managerial experience showed the least consistent perception of hospital governance. An exception to that was those having a score of 2 for managerial experience, also having a more consistent perception (low factor score) of hospital governance. This may be caused by a defect in the governance systems at these hospitals. Another exception was those having a management experience of 9, having a lower perception (higher factor score) of hospital governance. These may refer to some clinical managers, having high managerial experience, but with no involvement in the governing systems at the hospitals and more involvement in technical clinical professions.

6.1.6 Leadership role

As for the leadership role at the hospital independent variable, the Pearson correlation score analysis showed a weak negative correlation between the leadership role and the dependent factor score representing the perception of hospital governance. Figure 4.6 of the quantitative analysis chapter shows that respondents with low leadership roles had high factor scores (lower perceptions of hospital governance), while those with high leadership roles had low factor scores (more consistent perceptions of hospital governance). An exception is those having a leadership score of 3 out of 10. These respondents appeared to have a more consistent perception of hospital governance. This may be either

due to the weakness of the correlation between the variables, or to the fact that these may be physicians who have more consistent perceptions of hospital governance without being involved in leadership roles.

6.1.7 Management education

Concerning the management education at the hospital independent variable, figure 4.7 of the quantitative analysis chapter shows that those having formal and/or certified managerial education or training had a more favourable (lowest factor score) perception of hospital governance. This was followed by those having informal and/or certified managerial education or training. Then, those with the least favourable perception of hospital governance (highest factor score) were those of no formal or certified managerial education or training. This is logical as it reflects the necessity of managerial education or training in the involvement of respondents in the governance systems at the hospitals.

6.1.8 Years of work at the hospital

The years of work at the hospital independent variable was also related to the difference in perception of hospital governance. Figure 4.8 of the quantitative analysis chapter shows that those working from 0 to 5 years at the hospitals had the least positive perception (highest factor score) of hospital governance. Those working for 6 to 10 years at the hospitals had the most positive perception (lowest factor score) of hospital governance. Finally, those who worked for more than 10 years at the hospitals also had more negative perceptions of hospital governance.

Most of the previous literature deals with corporate governance in terms of its aggregate and theoretical definitions and structures, rather than in terms of its empirical existence and influence according to individual employees. None of the previous literature has contributed to finding methods for measuring the perception of corporate governance in general, and of hospital governance in particular.

Core et al. (1999: 375) state that “Measuring the effectiveness of the governance system is difficult” and hence corporate governance is a difficult

subject to research empirically. Moreover, in some cases, people either don't know 'what is happening at the top' or else don't want to speak about what they know for fear of possible consequences. Therefore, this research study created a tool for anonymously enquiring into and measuring the knowledge and perception of managers, clinicians, and members of the Board of Directors of hospital governance within the group of hospitals that they work at. The qualitative interviews supported the evidence from the quantitative data in measuring the knowledge and perception of hospital governance, hence making the quantitative and qualitative methods used for data collection in this specific field of study, an important contribution in this area of research. The qualitative interviews showed that the experience of corporate governance does not just relate to knowledge and one's perception of governance, but also can be determined by events in the workplace and the everyday experience of health care work. While there is statistical consistency demonstrated in the empirical research showing a shared definition of corporate governance, the qualitative research shows that individual experience of events at work determines the full meaning of corporate governance for each individual and this will vary with time, place, and position.

Therefore, it can be said that a new method of measurement of the knowledge and perception of hospital governance has been tested and proven to be successful in the framework of hospitals. This method is based on factor analysis through structuring surveys in a way to get a single factor score that directly represents the perception of hospital governance. This factor score can then be interpreted to reflect the degree of perception of hospital governance, and can be related, as in the case of this study, to different variables associated with demographic questions specifying personal characteristics of respondents. This method can be supported, as in the case of this study, by qualitative semi-structured interviews, showing the amount of knowledge and perception of interviewees to hospital governance, through indirect questions covering the concepts of corporate and clinical governance in the hospital sector. While there is shared definition of corporate governance, people's view of it and experience will vary according to their working situation. The qualitative data inevitably sees the impact of events, time, and place, and the fact that corporate governance is

an abstract overarching concept that is interpreted differently according to one's daily experience at work. Therefore, further research is needed to determine how consistent the corporate governance perceptions scores are over time, this given the likelihood that ongoing personal experience and organisational events will change staff perceptions over time.

Therefore, clear methods of performance measurement were perceived to be in use in each of the three hospitals (see table 5.1). Efficiency was perceived as highest in hospital Z, followed by a good efficiency in hospital Y, followed by a moderate efficiency in hospital X. Respondents to the survey indicated that they perceived that there are management deficits at each of the three hospitals. In hospital X, respondents indicated that there is no homogeneous management; respondents in hospital Y indicated that there are insufficient regulations; and respondents in hospital Z indicated that the general manager should have better education, knowledge, and background in hospital management. An absence of monetary incentives in all three hospitals caused by the financial crisis, which was mainly caused by a conflict of interest at the hospitals, arguably affects the overall performance of the hospitals. A good mission and a confidential strategic vision are implemented in the congregation. The board of directors has a minor role according to the perceptions of interviewees, and overall, many interviewees did not perceive the members board of directors to have adequate background and knowledge that allows them to sit on the board. For example, as mentioned earlier, a manager at hospital Z stated that "especially the members of the general council who may not even have some simple diplomas in this field". Clear hierarchal structures are present in all three hospitals, but the perception of the presence and the roles of the board of directors are minor. There is a lack of control performed over the CEO, allowing him to act independently of proper surveillance. Good relationships are present between clinicians and the management of each of the three hospitals, but the power given to physicians can have a disruptive effect on this relationship.

Critical realism generates awareness of the gap that perhaps inevitably exists between perception and what is real. This raises important issues for the study of corporate governance in organisations. For this reason, critical realism

directs attention to how relationships between the actual and the empirical are maintained. Clinical governance is another way in which relationships are produced and maintained between the actual, the empirical and the real.

6.2 Relationships between corporate and clinical governance

As the literature review showed, a common theme for all forms of governance is the agency problem, which agency theory attempts to explain through reference to organisational entities and mechanisms such as owners, managers, boards, and incentivisation (Zeckhauser and Pratt, 1985). Similar to corporate governance, clinical governance can also be explained through reference to the agency problem. Here, emphasis is placed on ensuring that clinicians and healthcare professionals, as 'agents' within the healthcare system, are accountable for quality and clinical performance (Mannion and Davies, 2002), being the interest of the owners and the stakeholders. This sheds light on other systems, entities, and mechanisms relevant to corporate governance that go beyond conventional corporate governance concerns.

The hospital corporate governance literature confirms the importance of clinical governance to corporate governance (Eeckloo, et al., 2007; Nicholls et al., 2000; Halligan and Donaldson, 2001; Buetow and Roland, 1999; Braithwaite and Travaglia, 2008). This has led to a broadening of the definition of corporate governance in the context of hospitals to involve aspects of organisational and clinical practice. For more than 40 years, the NHS implemented an unsuccessful implicit concept of quality, based on a conviction that the availability of well-trained staff, good facilities, and good equipment are enough to provide the recommended quality in the healthcare system (Scully and Donaldson 1998). In the 1990s, the concept of 'clinical governance' was established as "the main vehicle for continuously improving the quality of patient care" (Scully and Donaldson, 1998: 61). Since then, though its definition and degree of implementation vary, clinical governance has become an internationally recognised concept and set of mechanisms designed to focus effort and action planning around quality improvement and patient safety (Eeckloo, 2007).

A failure of clinical governance can become a corporate governance failure and similarly, a failure of corporate governance can directly affect the running of the hospital. The status of both corporate and clinical governance in the hospitals studied was measured through survey statements and further examined through detailed interview questions.

Quality of care and patient safety are focal points within clinical governance systems. In the hospitals studied, all participants who were interviewed described the standard of care at the hospitals in which they work as good. Within the organisational structure of each of the three hospitals are safety and quality departments, each with its own manager. Interviewees agreed that methods for dealing with medical errors at the three hospitals were clear and well-known.

Quality of care and patient safety at the three hospitals is perceived to be linked to clinical record keeping and reporting. There are efforts from the management of each of the hospitals and especially from the safety and quality departments to convince employees and clinicians to report everything, as to their minds, the primary aim of reporting is to spot errors and fix them, not to punish the persons responsible for the error. However, a lack of reporting was mentioned in the three hospitals, and in particular in hospital Y, with fear over the consequences of revealing mistakes cited as being a major cause of under-reporting.

Based on answers of respondents to the survey on corporate governance at the hospitals, the average degree of agreement for all respondents from the three hospitals to a statement on whether all serious clinical errors are investigated appropriately in the hospitals was 2.47 (Likert scale 1-5 where 1 = strongly agree and 5 = strongly disagree). Comparing the three hospitals for the same statement, the average result of hospital X was 2.57; that of hospital Y was 2.93; and that of hospital Z was 1.98 (ANOVA: $F=12.54$, $df=2$, $p=0.0001$). Based on responses to the survey, this shows that processes for investigating clinical errors are considered by respondents to be most effective in hospital Z, followed by hospital X, hospital Y.

In response to a further statement on whether it is difficult for hospital managers to prioritize patient safety and quality of patient care, the average degree of agreement was 3.14 (using the same Likert scale). Comparing the three hospitals for the same statement, the average result of hospital X was 3.42; that of hospital Y was 2.95; and that of hospital Z was 2.79 (ANOVA: $F=7.48$, $df=2$, $p=0.001$). It should be noted that answers of respondents in hospital X are close to signaling disagreement as a score of 4 refers to 'disagree', thus implying that it is not difficult for hospital managers of hospital X to prioritize patient safety and quality of patient care. However, this question was not one of the 16 retained for the overall factor scores of respondents' perception of hospital governance, and scores on this question do not correlate strongly with the factor scores. It nevertheless reflects the views of staff as to the extent that patient safety and quality of care are given priorities at their hospitals.

Clinical knowledge at the three hospitals was measured from the point of view of interviewees. All interviewees in the three hospitals were satisfied to a large extent with the quality of care provided by these hospitals, taking the available resources into consideration. This for example can be seen in a manager's statements on the quality of care. The manager at hospital X said: "in my opinion, in terms of physicians and nurses, its (the hospital) standard of care is very good"; another manager at hospital Y said: "with the things that we already have and already work with, I may say that we have a very good standard of care"; and another manager at hospital Z said: "I see it has a good standard of care both from the quality and safety aspects". All interviewees, some of whom were not clinicians, responded positively to questions concerning the level of knowledge of physicians in the overall functioning of the hospitals' services. All interviewees associated problems with the hospitals to be at the level of management and management systems. In their view, problems at these hospitals were caused by shortcomings in corporate governance and were not related to the skills and knowledge of clinicians.

Concerning the internal reporting systems, there is clearly a homogeneous 'theoretical' reporting system at the studied hospitals. As per the interviewees, it is clear in hospital X, but less clear in hospitals Y and Z. Most of the interviewed

managers said that they report either to the management or to the president of the hospital they work for, or both. But when studying the problems related to reporting, it can be seen that there are some major problems in the reporting system at these hospitals, interfering with the good 'theoretical' reporting system described by the managers. As previously mentioned, reporting directly affects the clinical governance aiming to provide the best quality and safety measurements. Hospital X has a major problem in its reporting system associated with the delay of response and the fear of being penalized as a consequence of reporting mistakes. In hospital Y, the reporting systems are clear in some departments, and unclear in others. Both the control of physicians caused by the system which indirectly allows them not to report, and the fear of reporting mistakes, all interfere with the good 'theoretical' reporting system described by the managers in this hospital. On the other hand, the reporting problems in hospital Z are focused on the physicians who do not report because of the power given to them, and that is allowing them to overcome the set systems by which they prefer to take the easier step of communicating verbally. Moreover, the fear of being penalized was not mentioned in hospital Z. It is also important to note that in hospital X, the power of physicians was not mentioned as a problem for reporting.

Therefore, in order to improve the reporting system, it should be clearly communicated and known by all members of the hospitals (employees, clinicians, etc...) in order to help decrease its problems and for everyone to know their duties concerning the reporting acts. Furthermore, the fear of reporting should be dealt with in a way to better get the maximum amount of reports possible, especially those declaring mistakes. The lack of reporting mistakes prevents the hospitals' management from managing their causes for future prevention. This allows for their repetition, reduces the performance of the hospital, and reduces the quality offered and the safety measures at the hospital. In addition, physicians at these hospitals should have the exact power which allows them to perform in the best manner, but not excess power which allows them to overcome the set systems, especially those of reporting; this should be worked on through the clarification of the reporting system, and through being able to set penalties for those who do not report properly.

As for the communication across this hierarchy, direct oral communication appeared to be the primary form of communication, being more used than the written form of communication, through reporting. Good verbal communication between members of a clinical team is incredibly important and a sign that the team is working well together, but this should not be at the cost of updating record systems. So since, according to interviewees, the verbal communication is somehow taking the place of reporting and updating records, this makes a major governance weakness that prevents daily acts from being documented and that aids in the prevention of reporting mistakes, thus directly affecting the clinical governance at the hospitals. For better clinical governance, the management should find ways to enforce the use of written forms of communication, documenting the verbal communication that is being commonly used.

Clinical governance is arguably related to clinical performance. However, whilst in conventional management systems, performance is managed through systems of incentivisation, target setting, and contracts, clinical governance is managed through standard setting. Standard setting applies to standards for medical reporting and documentation as much as it applies to professional standards. The average degree of agreement to a statement on whether clinical performance is managed appropriately through clear reporting at the hospitals studied was 2.46 on a likert scale of 5 (ANOVA: $F=3.51$, $df=2$, $p=0.03$). Comparing the means of the three hospitals for the same statement, the average result of hospital X was 2.61; that of hospital Y was 2.48; and that of hospital Z was 2.20. This shows that based on the answers of the respondents to the surveys, the presence of good reporting as means of measuring clinical performance is best at hospital Z, followed by hospital Y, and followed by hospital X. All these results are in line with the answers of interviewees on the system of reporting at their hospitals.

In corporate governance terms, ultimate responsibility for patient safety and quality of care lies with the hospital board. However, perceptions of accountability in the hospitals studied were diverse. Most of the interviewees answered differently when asked about to whom they consider themselves

accountable. As shown in the qualitative analysis chapter, the answers fluctuated between the hospital they work for, the president of the hospital they work for, the executive director of the hospital they work for, the organisation in general, the congregation which includes the hospitals, the medical committee of the hospital they work for, the general manager of the hospital they work for, and the chairman of the general council. Although all their responses are logical, there does not seem to be any clear set of accountabilities, and this reflects a diversity of opinion with respect to roles and their specification.

A common problem in the relationship between the clinicians and the management appeared to be present in hospitals X and Y. This problem is based on the power given to physicians and on allowing them to “consider that they are the ones bringing work to the hospital, while the management considers them as employees at the hospital” as stated by a manager at hospital X. “Physicians act as if they have the power”, stated a manager at hospital Y. Although interviewees in these hospitals said that the relationship is good overall, perceptions of physicians’ power continuously affects this relationship. Nonetheless, the relationship of clinicians with the management at hospital Z seems to be a good and close relationship as described by the interviewees.

Although some managers didn’t seem to have a clear knowledge of the corporate governance structures of the hospitals they work for, they did have clear involvement in clinical governance and a good understanding of what good clinical governance means. The standard of care was described as positive by most respondents, supported by quality and safety managers in all hospitals. The perception was that clear and well-known methods for investigating errors were in place at the three hospitals studied. The methods of dealing with clinical errors are best at hospital Z, followed by hospital X, and followed by hospital Y. Medical record keeping and reporting was described as a concern and in need of improvement in all the hospitals studied, which is a common finding.

Patient satisfaction, which is one of the goals of good clinical governance, was not described as a major concern by participants who often based their assessment on the 'loyalty' of patients and the average occupancy rates. The effectiveness of hospital organisation was perceived to be weak in all three hospitals, which could be speculated that it potentially affects quality and safety. Recommendations of the managers for improving the organisation of the hospitals were mainly based on corporate governance reforms.

The perception of survey respondents and interviewees was that clinical knowledge was good, which has implications for how the quality of health services that should be provided by the hospitals is perceived. The internal reporting system was perceived as being clear in hospital X, but unclear in hospitals Y and Z. Whereas, the power of physicians is described as problematic to maintaining good reporting systems in hospitals Y and Z. Perceptions of who is accountable for what within the hospital setting varied considerably. Each manager considers him/herself accountable to a different person/entity. Clinicians and senior managers at the three hospitals have good knowledge and experience in their fields, but the members of the general council don't seem to have them, according to interviewees. Finally, a conflict of interest seemed to take place on the level of the upper management. This case of conflict of interest will be discussed further in this chapter.

Findings from this research show that the state of clinical governance represented by the state of quality and safety at the studied hospitals is in good, but it is negatively affected by weak corporate governance mechanisms, thus showing a mutual, symbiotic relationship between the two forms of governance, where clinical governance has to be supported by corporate governance for its success.

Many of the available literature on corporate and clinical governance is descriptive, mentioning history and recommendations for good corporate and clinical governance structures. The OECD, for instance, provided principles for corporate governance that are a globally recognised benchmark for assessing and improving corporate governance (Jesover and Kirkpatrick, 2005). Similar to

the OECD principles, many committees and organisations have set recommendations for proper governance (eg. Farrar, 2008; Council, 2003; Tricker and Tricker, 2015; IFC, 2009). None of the available literature has gone deeper into practical analysis and assessment of the states of corporate and clinical governance at the level of the Lebanese hospitals. This study went deeper into the practical fields of three of the non-profit private Lebanese hospitals, and studied their states of corporate and clinical governance based on many of the basic constituents of these categories of governance systems. Each of the studied hospitals had its own specifications that differentiated it from the two others, while there appeared many common implemented governance strategies and governance defects in these same hospitals.

In articulating the relationships between clinical governance and corporate governance, this research makes a contribution to the study of hospital governance. It shows how failures in corporate governance can directly affect the functioning of the hospitals. It also shows how corporate governance failures may negatively affect the clinical governance at the hospitals.

Quantitative data produces a partial understanding of the phenomena that were studied. In this study's case, the quantitative method was used not to identify the real, but to increase the understanding of the actual. It checks the patterns within how people know corporate governance, as the method is more based on the epistemology than the ontology, since perceptions can be measured and compared, but they are time specific and dynamic over time. There will be differing perceptions in reaction to organisational events. In order to aid in the partial understanding of the actual, triangulation of both quantitative and qualitative methods was used. Qualitative interviews were performed with the aim of employing retrodution as an approach to critical realism. Through retrodution, both the result interpretations of the quantitative and qualitative data were joined into realistic analysis, producing a critical realist approach of actual events and real causes.

6.3 Influence of external factors and external stakeholders on internal hospital governance

Hospital governance is influenced both by internal relationships between owners and managers and by external relationships with external stakeholders. Arguably, clinical governance remains stable in the face of potentially disruptive corporate governance events because of the mechanisms through which it is linked to external stakeholders. Relationships to patients, as stakeholders, are described by those working at the studied hospitals as the reason for hospitals' existence and are therefore core to corporate governance from a stakeholder perspective.

Considering both quantitative and qualitative findings, it is clear that external stakeholders were a major constituent of the functioning of the hospitals. The research undertaken in these three hospitals show that participants do associate governance with key stakeholder groups. They perceive that external reference points, like professional organisations that contribute to governance, are as important to corporate governance as internal factors. The way that governance and the quality of care are described shows that systems are tied into professional bodies and frameworks of standards operating at a local and national level. These are external stakeholder organisations and governance systems that are, through both mechanism and experience, directly linked to the internal management systems of the hospitals. In many ways, this stakeholder involvement stabilises and improves clinical practice, management systems, and overall governance at hospital level because it includes relationships, organisations, and mechanisms that are independent from the corporate governance of a hospital or group of hospitals.

Stakeholder theory, being one of the major corporate governance theories that proved its importance alongside the classical agency theory approach, supports the finding that external forces are perceived to have an important influence on the creation of value and how to govern to ensure this value remains (Argandona, 2011). As Mayer (2013) argues, this factor is somewhat ignored by agency theory which calls into question the relevance of classical agency theory to hospital corporate governance.

When asked about the involvement of stakeholders in the overall system of the hospitals, interviewees at the three hospitals stated that some of their major tasks are related to external organisations and external requirements. The external organisations mentioned were universities, pharmaceutical companies, the Order of Physicians, the Order of Nurses, the Order of Midwives, the Syndicate of Private Hospitals, the Ministry of Labour, the Ministry of Public Health, the Ministry of Finance, insurance companies, and the Social Security (similar to NHS in England). Moreover, it was deduced from the interviewees' answers that dealing with these external stakeholders was mainly in the hands of the upper managers, while lower level personnel and those on the lower levels of the hierarchy dealt only with internal stakeholders. Figure 6.1 provides a map of key external stakeholders for the three hospitals.

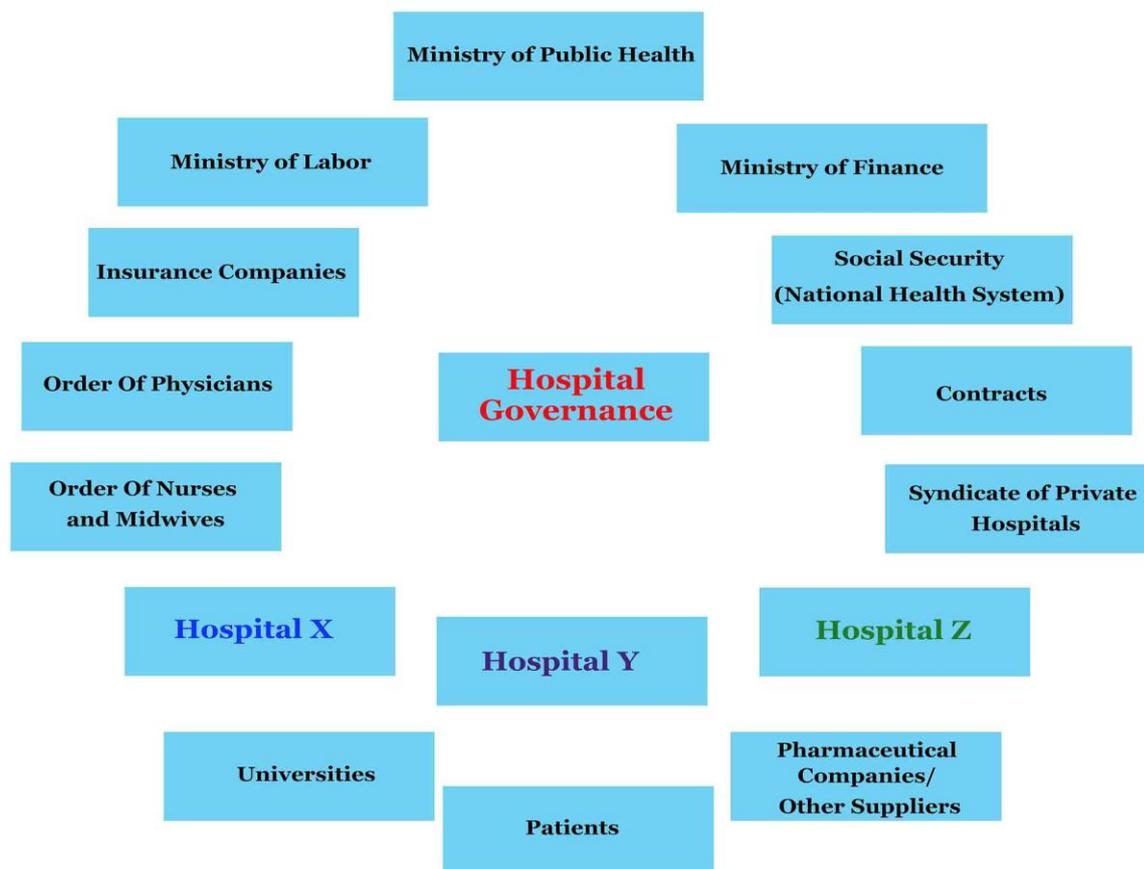


Figure 6.1. Diagram of External Stakeholders Described in Interviews

Each of the different external stakeholders has a different influence on the hospitals to those whose interests are at stake. Each of them also influences

the performance of the hospitals differently. Some universities, for example, have agreements with hospitals X and Y as they send them medical and nursing residents for internship and training. A manager at hospital X said: “we are now in collaboration with University X and I collaborate with them for this purpose as they send us residents to this hospital”. Similarly, a manager at hospital Y stated: “We also collaborate with universities. We are in direct contact to help them in their training. I send them nurses for training.” This by itself needs preparation and significant organisational capacity to be able to fulfill the educational and demographic needs of students. Pharmaceutical companies, which supply the hospitals with medications and certain medical equipment, directly affect the internal functioning and performance of hospitals, because any lack of adequate supply by these companies may directly affect the clinical governance at these hospitals, through deterioration in the services provided. The Order of Physicians protects the physicians’ rights, defines professional standards, and protects the safety of patients, continually seeking ways to improve quality of care. It offers Continuing Professional Development opportunities and conferences to improve and update physician knowledge and skills. It also assists the hospitals in providing specific forms of training for the physicians and managers of the hospitals. Moreover, it provides working permits to physicians. Similarly, the Orders of Nurses and Midwives provides nurses with training, regulations, standards and rules, whilst protecting the rights of nurses and midwives, and supporting their application for work permits.

The Syndicate of Private Hospitals works on protecting the rights of the owners of hospitals in the private sector, both for-profit and non-profit hospitals. It also offers relevant training for professionals. The Ministry of Health aims to provide adequate health for all citizens and foreigners residing in Lebanon. Thus, it has direct contact and influence on the performance of all hospitals. It is involved in the quality of health provided by the hospitals and it offers accreditations that guarantee this quality. The Ministry of Labour works on protecting the rights of all employees, including clinicians. The Ministry of Finance follows up with the hospitals to make sure they are properly fulfilling their duties towards the government, in terms of the proper presentation of their accounting outcomes. In most cases, this puts obligations on hospitals to pay certain taxes based on

their income. Non-profit organisations are exempted to a large extent from these taxes, such as in the case of the hospitals studied. Insurance companies directly influence the hospitals' functioning as they are one of the major sources of money for the hospitals, given that in Lebanon, the majority of the population is not supported by National Social Security, and is therefore dependent on insurance companies for health funding. The National Social Security protects the rights of employees with respect to getting medical support from the National Social Security office via their employer, and makes sure that the hospitals register all employees in its services.

An example that shows how external stakeholders may affect the internal governance and performance of a hospital are nursing salaries which are set by the Order of Nurses. This commits the hospital to paying nurses specific salaries. On the one hand, this means hospitals cannot incentivise nurses through paying bonuses or implementing performance related pay. On the other hand, it prevents nurses from being paid below a given standard by hospitals. The Lebanese government has raised the set minimum wage to 675'000 LBP for any Lebanese worker. Nonetheless, as stated by a manager at hospital X, when referring to the salaries set by the Order of Nurses and to the minimum wage set by the Lebanese government, "both of these salary categories are not enough for a decent living". This by default will negatively affect the performance of all employees, including nurses, and will therefore affect both the clinical and corporate governance systems of the hospitals they work in.

The government, represented in this matter by the Ministry of Health, can also have a negative effect on the internal performance of the hospitals due to lack of central government funding. In hospital Y for example, a manager stated that "we have some problems with our hospitals, sometimes caused by the lack of funding from the government, the money we already need from the government." Here, the delays of the government in paying its liabilities affect the overall performance of this hospital, especially in its case, where the hospital owners are experiencing a period of financial difficulties. In designing an instrument to measure employee perceptions of corporate governance, the statement which asks respondents to consider whether the Ministry of Public Health has 'too much influence on this hospital', produced an overall average

score for all three hospitals of 2.53, while the average for hospital X was 2.56, that of hospital Y was 2.67, and that of hospital Z was 2.39 (ANOVA: $F=1.403$, $df=2$, $p=0.248$). The one-way analysis of variance (ANOVA) showed no statistically significant differences between the means of the independent variables, but since the standard deviation is 0.85, this shows that most respondents tend to agree with the statement overall. Moreover, this question was not one of the 16 retained for the overall factor scores of respondents' perceptions of hospital governance and scores on this question do not correlate strongly with the factor scores. It nevertheless, shows that staff recognises the influence of the Ministry of Public Health on the hospitals.

Similarly, in response to the statement that asks whether the Syndicate of Hospitals pays too much attention to achieving benefits for the owners of this hospital, the overall average score for all three hospitals was 2.62, while the average for hospital X was 2.77, that of hospital Y was 2.71, and that of hospital Z was 2.3 (ANOVA: $F=7.069$, $df=2$, $p=0.001$). This shows that the Syndicate of Hospitals is perceived by respondents to pay more attention to achieving benefits for the owners of hospital Z, than those of hospitals Y and X, respectively. It is noteworthy that in this case, the owners are the same, represented by the congregation as a whole; the congregation being the religious assembly that includes the hospitals studied.

Similarly, in response to the statement that asks whether the Lebanese Order of Physicians strongly represents the physicians' interests in this hospital, the overall average score for all three hospitals was 2.43, while the average for hospital X was 2.59, that of hospital Y was 2.48, and that of hospital Z was 2.15 (ANOVA: $F=5.054$, $df=2$, $p=0.007$). This shows that the Lebanese Order of Physicians is perceived to represent the physicians' interests better in hospital Z, than in hospitals Y and X, respectively.

Similarly, in response to the statement that asks whether external factors such as politics or the economic situation of the country have too much influence on what happens in the hospital, the overall average score for all three hospitals was 2.02, while the average for hospital X was 2.04, that of hospital Y was 2.10, and that of hospital Z was 1.95 (ANOVA: $F=0.332$, $df=2$, $p=0.718$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the independent variables, but since its standard

deviation is 0.92, this shows that most respondents tend to agree with the statement overall. Moreover, this question was not one of the 16 retained for the overall factor scores of respondents' perception of hospital governance and scores on this question do not correlate strongly with the factor scores. It nevertheless, shows that staff recognises the influence of external factors on the hospitals. This proves what has already been deduced; that external factors have a significant influence on the internal functioning and on the hospital governance at these hospitals.

Finally, in answer to the statement that asks whether patients (as stakeholders) are able to rely on the law to hold clinicians to account, the overall average score for all three hospitals was 2.39, while the average for hospital X was 2.43, that of hospital Y was 2.29, and that of hospital Z was 2.38 (ANOVA: $F=0.482$, $df=2$, $p=0.62$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the independent variables, but since its standard deviation is 0.82, this shows that most respondents tend to agree with the statement overall. This question was not one of the 16 retained for the overall factor scores of respondents' perception of hospital governance and scores on this question do not correlate strongly with the factor scores. It nevertheless, shows that staff recognise the influence of patients and their experience on the hospitals. Logically, the answers of respondents from the three hospitals should be almost the same, as all patients are covered by the same Lebanese Law and there is no statistical difference between the three hospitals in the survey. However, it is clear that patient satisfaction is a major concern in the hospitals being studied. As shown in the qualitative analysis chapter, loyalty of patients has been mentioned for hospital X. It was also mentioned that patient satisfaction in hospital Y is being followed up on as much as they can. This is also directly related to the presence of safety and quality managers in all three hospitals.

Patient satisfaction from the interviewees' point of view is measured through loyalty and the average occupancy rates, not taking into consideration the environment around them and whether patients are obliged to go to their specific hospital because of a possible lack of availability of other hospitals, or better hospitals in the same geographic area, or because of their better priced

health services. They do not take into consideration the complaints of patients and their overall satisfaction based on the success of the clinical aspect in solving their health situation.

According to Edward Freeman, who originally detailed stakeholder theory of organisational management, the corporation exists for the purpose of serving its stakeholders (Freeman, 1984). As per Mayer's (2013) and many other supporters of the stakeholder theory approach, the basic definition of corporate governance should be broadened to incorporate a broader view of whose interests are at stake when we consider the success or failure of corporate institutions. There are inter-relationships between stakeholders and other external factors that have effects on the internal governance of corporations. According to Freeman (1984), a firm's decision should also be aligned with the interests of different players within and outside the company. Stakeholder theory, being one of the two major theories of corporate governance, argues for the importance of including all stakeholders in the daily actions and decision making processes of the organisation (Mayer, 2013). It also aims to maximize value for stakeholders alongside principals and agents.

In the hospitals studied, there appeared to be clear involvement of external stakeholders in the management and clinical processes taking place. Moreover, it is clear that stakeholders have a tangible influence on these hospitals that goes beyond questions of perception. This study therefore confirms the importance of stakeholder theory in the overall functioning and performance of hospitals. It also adds new dimensions by showing that when value is maximized for the benefit of stakeholders, this has the effect of benefitting the hospitals too.

Therefore, it can be concluded that the involvement of external stakeholders in hospitals is essential and core to its overall capacity to function. Other authors on hospital corporate governance have alluded to this finding through reference to the significance of corporate social responsibility in hospital governance (Freeman, 1984; Post, et al., 2002; Perrini, et al., 2006; Rosam and Peddle, 2004; Grosser and Moon, 2005; Bhimani and Soonawalla, 2005; Jamali et al., 2008). However, the aim of this research is to identify the mechanisms that

underpin hospital corporate governance rather than designate responsibilities. Through this lens we see that stakeholders' involvement in the governance systems of any corporation and of hospitals in particular are stabilized through both obstructing and enabling change. This is because, as stated in the qualitative analysis chapter, involving stakeholders means admitting relationships, organisations, and mechanisms that are independent from the internal corporate governance of an individual hospital or group of hospitals.

This study contributes in providing evidence of the importance of the stakeholder approach to hospital governance and demonstrating the influence and roles of external factors on internal hospital governance. It shows that staff recognizes the degree of involvement of the external stakeholders in the internal hospital governance and their functionality. From a critical realism perspective, respondents at the studied hospitals are more likely to have knowledge of relationships they engage in on a routine basis. Interviewees, for instance, confidently talked about the different stakeholders they work with. They seemed to have quite a good knowledge in this aspect; their working relationships inform their perceptions.

6.4 Corporate governance events

One of the ways in which corporate governance manifests more clearly to managers in an organisation is when there is a 'corporate governance event'. An event is "A thing that happens or takes place, especially one of importance" (Oxford Dictionary, 2017). In the case of corporate governance, as in this study, the events can be failures or strong corporate governance actions. One of the main mechanisms of sound corporate governance is making senior managers accountable; in other words, making the agent accountable to the principle.

Two major corporate governance events took place in the studied hospitals. The first was the 'financial crisis' that the hospitals are facing. This was followed by a second event that was the sudden departure of the CEO of the three hospitals. A very interesting phase of this research study was that during its process, and specifically during the data collection process, the CEO of the three hospitals suddenly left his position.

A noticeable aspect of the interviews was that many of the participants in this study were not knowledgeable of or were not willing to express knowledge of, the causes of these events and some were 'surprised' by what happened. Others seemed to hide information, or felt they did not want to answer such questions, and did not want to discuss this issue. For example, when asked about whether the CEO can prioritize his personal interests over those of the hospitals, a manager at hospital Z said "I don't have a direct relationship with the CEO, so I cannot answer such question." Likewise, a manager at hospital Y asked if he may skip the question.

Although many of the interviewees either did not know enough about the corporate governance events, or did not want to share their knowledge, a manager at hospital X gave some clarifications in this aspect. When asked if the CEO can prioritize his personal interests over those of the hospitals, he answered with the following:

"In theory, he should not prioritize his personal interests. In fact, I am surprised by what happened; we all are, and we are sad about it. But as an answer to this question, I don't know here if the CEO was really able to do whatever he wants without control, or whether other people are involved."

This creates a question mark around whether the corporate governance events were caused by the CEO himself or whether other people are involved in the financial crisis that led the CEO to leave his position. Moreover, a manager at hospital X also said:

"What happened in fact is that the CEO left the hospital due to problems that happened with him. He was replaced by a committee constituted of different people and professionals. This committee is responsible now for the management of the hospital."

When this manager was asked to describe the cause that led the CEO to leave, he said:

"The congregation found that it is losing financially rather than improving as it was planned, so the general council decided to change the CEO. The debt has exponentially increased. They told him that you did not succeed at your job, so you have to leave. That's what I know; I am not deeply involved, and I do not know all the details."

After that, the manager was asked if he describes the case as a conflict of interest. His answer was “I am not really involved in the details, but I think yes.”

As a way of preventing the CEO from prioritizing his personal interests over those of the hospitals, a manager at hospital Z mentioned that “the salary of the CEO is very high, and this normally should prevent him from doing his personal interests over those of the hospital.”

When asked about how to improve the efficiency in hospital X, a manager suggested a more homogeneous management that should be able to stop the corruption, the waste, and the squandering of money, and specify more accurately the exact roles and requirements of each of the managers because roles are overlapping. So based on his answer, he was asked if these are some of the causes of the problem that happened with the CEO, and he answered with a “Yes”. His answer indirectly accuses the CEO of being responsible for the crisis, represented by the corruption and the waste and squandering of money.

The financial crisis led the three hospitals to pass through a difficult phase. A manager stated that “we are now able again to pay salaries on time, sometimes with a delay of 4-5 days. So now we’re back on track from this aspect; last month’s salaries were paid to all employees”. This shows that the crisis was considerable and led to employees and clinicians not being paid on time.

The results of the two corporate governance events were challenging and difficult for the hospitals of the congregation. When asked about whether there are good incentives at hospital X, a manager said “right now, honestly, there are no incentives... both financially and morally”. Another manager answered to the same question:

“not much these days, there are no monetary incentives at first.... Moreover, we used to have a CAPN (Contrat d’Activite Periodiquement Negotiable) program which used to give incentives based on activity. This was put on hold this year, and we are waiting to see how the policy will change”.

Similarly, a manager at the same hospital said that the CAPN is postponed due to financial reasons. Also, a manager at hospital Z said “honestly, we had an incentive that was a bonus related to performance. But now it is being on hold”. In fact, based on these and many other answers of interviewees, the presence of real incentives was not available anymore after what they called the ‘financial

crisis' that has been interpreted as a major corporate governance event at the hospitals.

As for the answers of respondents to the survey on the governance at the hospitals, the average degree of agreement for all respondents from the three hospitals to a statement on whether it is the responsibility of the general council to ensure good independent financial audit of this hospital was 2.18 (ANOVA: $F=4.86$, $df=2$, $p=0.009$). Comparing the three hospitals for the same statement, the average result of hospital X was 2.04; that of hospital Y was 2.19; and that of hospital Z was 2.43. This statement did not correlate with other opinions on governance, so it was not included in the overall measure of perceptions of hospital governance. It nevertheless specifies to whom the responsibility for financial audit is given in the studied hospitals and suggests that the majority of staff agree with this form of corporate governance and accountability for senior managers. In the case of these hospitals, the general council is mainly responsible for the corporate governance event represented by the financial crisis that took place in the congregation, as one of its primary roles was to ensure good independent financial audit. So, in the case of this corporate governance event, one possibility may probably be that the general council either did not hire independent financial auditors, or did not take the full responsibility to follow up on the auditing results. They nonetheless took action by sacking the CEO. The collected data could not go deeper into the analysis of internal confidential actions concerning the firing of the CEO, but an important theme is that events can get deteriorate significantly before corporate government actions to intervene are taken, as in the cases of Worldcom and Enron. In the case of the hospitals studied, it can be deduced that the corporate governance actions to the financial failures happened at a late stage, like in the case of Worldcom and Enron. This was because the financial status was very serious, causing the staff not to be paid adequately at the regular periods.

The average degree of agreement for all respondents from the three hospitals to a statement on whether the general council will hold the relevant manager responsible if a serious mistake is made with hospital financial accounting was 2.33 (ANOVA: $F=11.57$, $df=2$, $p=0.0001$). Comparing the three hospitals for the same statement, the average result of hospital X was 2.02; that of hospital Y

was 2.6; and that of hospital Z was 2.67. This shows that based on the answers of the respondents to the surveys, there is significant agreement on the statement that the relevant manager responsible for financial accounting mistakes is held responsible. This can be reflected by the departure of the CEO as he is the one responsible for the resulting financial performance. Similarly, the average degree of agreement for all respondents from the three hospitals to the following statement “not all hospital managers are responsible for the financial performance of the studied hospitals” was 2.3 (ANOVA: $F=0.789$, $df=2$, $p=0.455$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the independent variables, but since its standard deviation is 0.94, this shows that most respondents somehow agree with the statement overall. Moreover, these two statements did not correlate with other opinions on governance, so they were not included in the overall measure of perceptions of hospital governance. They nevertheless show how financial responsibilities are perceived at the studied hospitals.

Based on the answers of the respondents to the surveys, there is a significant agreement that the relevant manager responsible for financial accounting mistakes is held responsible. This can be reflected by the CEO's leaving as the CEO is the one responsible for the resulting financial accountability. None of the data collected shows any resulting actions taken on behalf of the general council, as it should also be responsible for the corporate governance event that took place, given that they are responsible to follow up on the independent financial auditing (Klein, 2002; DeZoort and Salterio, 2001).

Moreover, answers of respondents on a statement that checks whether the CEO is well-paid for the level of responsibility he has were as follows: the average result of hospital X was 2.67; that of hospital Y was 2.33; and that of hospital Z was 2.18, with an average result of 2.46 for all three hospitals (ANOVA: $F=8.85$, $df=2$, $p=0.0001$). This statement did not correlate with other opinions on governance, so was not included in the overall measure of perceptions of hospital governance. It nevertheless shows that based on the knowledge of the respondents, the CEO is well-paid for the level of responsibility he has. Therefore, as for the indirect description of the corporate governance event of the financial crisis as being caused by a conflict of interest case, the CEO's wage seems to be good for the level of responsibility he has.

This wage should incentivise him to work better for the benefit of all stakeholders, and specifically the owners, and should also prevent him from using his powers to make conflicts of interest. Nonetheless, given the nature of corporate governance, the CEO alone cannot be held responsible for corporate governance failure, as other persons may be accountable or involved in its causes, as stated by a manager at hospital X.

As previously stated in this chapter, according to the answers of respondents to the questionnaires, the average degree of agreement on a statement that checks whether there should be more control over how the CEO spends the hospitals' money was 2.3 for all three hospitals (ANOVA: $F=4.63$, $df=2$, $p=0.01$). The answers of respondents show that they probably felt that there is a lack of control provided over the actions of the CEO in terms of spending the hospitals' money. This shows an overall agreement with the idea that there is a lack of control over how the CEO is spending the hospitals' money. The average degree of agreement of the respondent to the above statement showed that they almost equally agreed to it. This was also supported by a manager at hospital X who said that

“the general council must have good control over the CEO – the CEO should not have the total power over everything without communicating and taking instructions from the general council”.

In this statement, she is presenting a very important method on how to prevent the CEO from prioritizing his personal interests. A clear accusation to the system was mentioned by a manager at hospital Z by saying: “in these hospitals, the CEO can easily prioritize his personal interests over the interests of the hospital due to the system overall”. This lack of control over how the CEO was spending the hospital's money may have been the primary element that caused the corporate governance events at these hospitals.

Also, as previously stated in this chapter, according to the answers of respondents to the questionnaires, the average degree of agreement on a statement that checks whether respondents think that all hospital managers should have fixed-term employment contracts which are reviewed and renewed against their performance was 1.83 for all three hospitals (ANOVA: $F=0.134$, $df=2$, $p=0.875$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the three hospitals, but

since its standard deviation is 0.78, this shows that most respondents tend to agree with the statement overall. No data shows whether the CEO's contract was a fixed-term contract, but - based on his performance, he had to quit his job position.

Answers of respondents to a statement which checks whether respondents think that the CEO cannot prioritize his personal interests over those of the hospitals were as follows: the average result of hospital X was 2.3; that of hospital Y was 2.19; and that of hospital Z was 2.08, with an average result of 2.21 for all three hospitals (ANOVA: $F=1.14$, $df=2$, $p=0.322$). The one-way analysis of variance (ANOVA) shows no statistically significant differences between the means of the three hospitals, but since its standard deviation is 0.89, this shows that most respondents tend to agree with the statement overall. This somehow contradicts with what was described by the managers at the hospitals. The answers of respondents to this statement are more theoretical than practical; this may be due to the lack of knowledge of many of the respondents to this point, caused by their distant roles from the CEO and the general council. These answers show that respondents may not have the adequate perception of whether the CEO can prioritize his personal interests over those of the hospitals or not. This can be proven by the fact of the CEO having to leave his job and its causes. The answers of the respondents seem to be more theoretical than practical as most of them may not be knowledgeable of the system for the accountability of the senior managerial levels. The staff expect the CEO to be accountable.

The importance of corporate governance increased with the collapse of big companies. Rules and regulations were enacted for this purpose, in order to control the functioning of systems and companies, and to try to prevent corporate governance failures that cause the deterioration of companies.

In corporate governance, agency theory is concerned with the relationship between two parties: the principal and the agent. As explained in the literature review chapter, an agency relationship arises whenever one individual depends on the action of another (Zeckhauser and Pratt, 1985). Whenever a principal delegates control or decision-making authority to an agent, an agency relation arises. An agency problem arises whenever one of two problems that the theory

raises happens: The first problem occurs when a conflict (sometimes a conflict of interest) occurs between the agent and the principal, accompanied by a difficulty or high expense for the principal. The second problem arises when the agent and the principal have different approaches to risk; one is risk averse and the other risk taker, and each is willing to take different actions towards this risk (Jones, 2010). In the case of the corporate governance events that took place at the studied hospitals, there appears to be a conflict of interest that created an agency problem, leading to the CEO's quitting of his job. Moreover, there may have been a difference in the risk approaches of the CEO and the general council that contributed in the corporate governance failures that took place. Corporate governance has a known relationship to financial reporting. Corporate governance failures can lead to financial reporting failures and vice versa. Most of governance failures are results of the manipulation of financial reporting to show that good performance is achieved (Norwani et al., 2011). The quantity of information disclosed in the annual reports of organisations, and the time the information is released are influenced by the board of directors' decisions. The board of directors should have different committees including audit committees that assure good quality (Brennan and Solomon, 2008) and transparency of financial reporting (McGee and Yuan, 2008).

Therefore, it can be said that two major corporate governance events took place in the studied hospitals during the last couple of years. These events were failures in the corporate governance system of these hospitals. They are represented by the 'financial crisis' that was followed by a sudden departure of the CEO. There was a clear agency problem that took place in the form of a conflict of interest. There was no definite accusations, but the departure of the CEO and the answers of some of the interviewees on this issue, place question marks around whether the CEO was the only one responsible for these failures. Based on the feedback of the participants in this research, it can be inferred that the role of the board of directors of the studied hospitals (known as the general council) was not as it should have been.

The corporate governance events that took place in the hospitals had negative effects on both the corporate and clinical governance. The departure of the CEO was a 'surprise' to many of the managers at the hospitals. A breach in the

hierarchical structure of the hospitals led to further internal problems that the general council tried to prevent, through setting a temporary committee to replace the CEO. No tangible evidence was collected to show how the failures of the corporate governance affect the clinical governance; but the financial problems that led to problems in internal funding, resulted in problems in paying clinicians and other staff. As a result, there has been an ending for the time being to the financial incentivisation strategies each of the hospitals was implementing. These can easily cause shortages in the quality of health provided, and thus cause a weakness in the clinical governance systems of these hospitals.

This study contributes in articulating the consequences of real time examples of corporate governance events in the form of corporate governance failures. It shows how cases of conflict of interest may happen inside corporations, and particularly in private non-profit hospitals. It also shows how staff and managers in the hospitals experience these events, and shows how they describe them. It demonstrates the extent of involvement of the participants of this study in the hospital governance system and mechanisms. It also tests the perception of interviewees to responsibilities and roles of each of the internal stakeholders at the hospitals.

Knowledge is held by different people in different ways. Events have the potential to change people's perception of corporate governance as they are real manifestations of corporate governance happening. Many of those who worked at the hospitals studied may not have known the corporate governance mechanisms at their hospital until the time that the CEO left. The hospital, like most other organisations, is a dynamic environment. Things frequently change, and perceptions of functions and mechanisms also change. This is why the qualitative semi structured interviews resulted in an understanding of how managers have experienced this corporate governance event. The survey was undertaken before the period when the CEO left. If this same survey was performed for the same population after the departure of the CEO, it would be expected that results of the perception of corporate governance would change. While the research has shown that staff in the three hospitals share some perceptions and understandings of what corporate governance is, this does

vary according to their individual situation. In part, differences in individual perceptions result from their employment role, the hospital in which they are located, their knowledge of events, and what the specific management issue affecting them is.

Structures of corporate governance refer to the real in critical realism terms. People in the hospitals do not have and in most cases should not be expected to have, a complete understanding of corporate governance. According to Bhaskar's philosophy, people will have only some knowledge of what is real, and there will always be a gap between what people know and experience, and between what is real. In the first section of this chapter, the research study tried to explore what people at the hospitals experience and know. It explored how far people's knowledge of corporate governance is from reality; taking the literature on corporate governance as the reality. Based on a critical realism interpretation, people will only know corporate governance partially: they will only have a partial understanding of it. This is normal as opposed to people who totally lack the perception of governance. Using the language of critical realism, it is quite unlikely that people have a complete and unified understanding of this type of concept.

It is really important that people have good perceptions of corporate governance at the hospitals for different reasons: When most of the staff at the hospital knows the mechanisms of corporate governance at this hospital, they can go back and know to whom they should refer in certain circumstances. When defects happen at the managerial level or at the level of the board, they can easily specify responsibilities and set the accountability of those who are concerned with the defects. Whenever mistakes or conflicts of interest take place, they can set responsibilities. Whenever those at the higher hierarchical levels know that most of the staff at the hospital have good perceptions of hospital governance, they will think twice before doing any conflicts of interest or any pre-planned mistakes, as there will be a greater number of people to hold senior managers and board members into account, when people understand the mechanisms of governance at the hospitals.

Finally, this thesis contributed in finding a tool to measure the perception of hospital governance; it studied the relationships between corporate and clinical governance in hospital settings; it checked for the external stakeholders' involvement in the daily functioning at the hospitals studied; it also studied how corporate governance events affect and influence the performance and corporate governance mechanisms at the hospitals. There is potential for further developing this tool in future research, to test participant repeat scores over time, and scores in different cultural settings.

Several practical recommendations might come out of this study, and these will be discussed in the conclusion that follows.

Chapter 7

CONCLUSION

Although corporate governance is a continuously growing area of research, there are many areas that require further exploration. Extensive research has been conducted on the subject of corporate governance in the last decades. Many theories, definitions, and concepts of corporate governance have appeared in the literature. Many of these are theoretical concepts that are not well-grounded in empirical research. However, there is still no single, universally accepted mechanism of good governance. This, in turn, is related to ontological approaches for dealing with this topic, as researchers cannot pursue a single truth on how governance structures and mechanisms should function. This research study enhanced the literature on corporate governance through studying the hospital governance in the Lebanese settings, using an alternative conceptualization based on Roy Bhaskar's philosophy of critical realism. The mentioned philosophy argues that the way things are, affects the ways we know them, and the extent to which they can be known.

This research study has examined the concept of corporate governance in the context of hospitals, known as hospital governance. It focused on the hospital governance of non-profit private hospitals in Lebanon, taking three hospitals as focused examples of the governance systems in such settings. The names and all other indications that may give guesses of the hospitals' identities were changed for confidentiality purposes. This research study also critically examined the relationships between corporate and clinical governance as subsets of hospital governance, showing how the governance concept is evolving in the hospital context, and supporting the understanding of the role of clinical governance in the overall hospital governance. It studied how governance systems and their implementations affected the performance at the hospitals, and the effect of incentivisation measurements on the performance. It also focused on the stakeholders served by the hospitals, examining the influence of external factors on internal hospital governance. Moreover, it compared the governance processes between the three hospitals studied.

The study employed a mixed methods approach, using both a quantitative survey of 207 clinicians and managers, and qualitative in-depth semi-structured interviews for managers from the three hospitals. With the use of these methods, different corporate governance theories, basically the agency and stakeholder theories were critically examined for their relevance to understanding hospital governance. The nature of governance was also studied from these theoretical points of view, by using the experience of those who work at the hospitals.

The quantitative survey was used as a new tool to measuring the perception of hospital governance at the hospitals studied. While the research was strong on place validity more research is needed in similar and replicated studies, to consider if the results can be generalized to other hospitals in the future. Interesting results were obtained after specifying the factor score representing the perception of hospital governance at these hospitals, through the use of factor analysis technique of data analysis. When studying the relationship between demographic variables and factor scores, consistent overall measures of perceptions of governance resulted with differences within these perceptions. Statistical evidence showed that perceptions of governance did not differ by age or gender. As for the respondents' role at the hospitals, members of the board of directors and non-clinical managers showed higher levels of perception of hospital governance than physicians and licensed nurses, and licensed nurses had the least consistent perception of hospital governance. Members of hospital Z had a higher perception of hospital governance than hospitals X and Y, respectively. Regarding the managerial role, leadership role, and management experience of respondents, those with the highest roles/ experience seemed to share a consistent and broadly accurate perception of hospital governance, while those with lower roles/ experience had lower perceptions. As for the management education, those having a formal and/or certified managerial education or training had a more favourable perception of hospital governance than those having an informal and/or certified managerial education or training, and those not having any formal or certified managerial education or training, respectively. Those working from 0 to 5 years at the hospitals had the least positive perception of hospital governance, followed by those working for more

than 10 years, followed by those working for 6 to 10 years at the hospitals, having the most positive perception of hospital governance.

The qualitative semi-structured interviews supported the quantitative surveys in studying the perception of hospital governance at the hospitals studied. Interviews also contributed to knowledge of the states of corporate and clinical governance at the hospitals, through giving clear positions of the states of quality, safety, reporting systems, performance, involvement and structure of the board of directors, internal relationships, clinical knowledge, conflicts of interest, agency problem, standard of care, communication, hierarchical form, accountability, control, power, and incentivisation. They also contributed in specifying the hospitals' stakeholders, and in studying the influence of external factors and external stakeholders on the internal hospital governance. Moreover, they supported agency theory by highlighting corporate governance events that directly affected the overall hospital governance, giving clear examples of how such events are caused by a lack of adequate governance systems, and how they directly affect the performance, the mechanisms of management, and both the corporate and clinical governance at the hospitals. The main corporate governance event was the departure of the CEO. Its primary cause may have been related to a deficiency in the structure and implementation of the corporate governance system, as previously discussed in the thesis.

The theoretical framework used in this research is critical realism which is frequently used in social sciences for mixed methods (Venkatesh et al., 2013), supported by the triangulation of the research methods used. Taking corporate governance as the real, this study measures the extent to which people at the hospitals know the real. Therefore, perception of hospital governance has been studied, measuring the extent to which people are aware of hospital governance at the hospitals they work at, based on the different demographics that differentiate respondents of the study. The study also aimed to check how far people's knowledge of corporate governance is from the reality, taking the literature on corporate governance as a form of reality. This perception was measured through the retrodution of both quantitative and qualitative methods of data collection and analysis. The results proved critical realism's philosophy

that people will only know corporate governance partially, and will only have a partial understanding of it.

Therefore, this study has examined the nature of corporate governance as a concept, with evidence of the overall concept provided by the survey, while the qualitative interviews showed the important contextual influences and impact of events on how staff actually experience governance. This shows why mixed methods is so important to this research area and why the study design did not just focus on developing a single questionnaire, repeated in different hospitals.

As a result of the analysis of all the data in the three hospitals studied, a number of possible ideas for the future development of hospital corporate governance are raised. The board of directors of the three hospitals studied appear to need an amended structure, role, and more involvement in the direction of hospitals; since the lack of involvement may have been one reason that led to a decline in the appropriate functioning of the hospitals, leading to some governance failures that included the unplanned exit of the CEO. Better reporting systems to the board could be used, and to hopefully overcome the already-mentioned obstacles in the reporting systems. Better strategies could be implemented to support the incentivization models at the hospitals, giving this topic adequate importance as it boosts the efficiency of employees in their daily efforts. A better balance of power can be executed, thus balancing the power mechanisms for a better realised hierarchical system. People's perception of hospital governance may be enhanced through a pre-planned model, including communication tools and other proper methods like the distribution of surveys on corporate governance as an educational tool on this topic, and like providing a more open use of management documents and resources, like sharing the strategic vision documents which may hold the board and the senior manager into account concerning their proper implementations. Finally, the hospitals studies may have a public and employee-facing strategy document, probably a detailed strategic vision document that is public, and non-confidential as they already have it. This could act a resource for informing those within and outside the organisation about the board, their mechanisms, structures and priorities. It could also act as a resource for informing and

engaging external stakeholders on the strategies and visions that the hospitals are implementing.

The originality of this study lies in indirectly proving that employees and managers do have a stable perception of governance and it is possible to know if their perceptions are accurate, favourable, consistent, or critical. It is also clear that this knowledge is dynamic, influenced by the particular time period that perceptions are measured, a person's position and role in the organisation and by the level of management education they have been able to access. Arguably it is of benefit to hospitals that staff have a positive perception and adequate knowledge of hospital governance mechanisms as this can produce better adherence to governance mechanisms and improved accountability. This could support a positive view of boards and management structures more generally, probably leading to fewer mistakes and fewer risks of conflicts of interest as directors on the board and senior managers will be aware that there will be more people to directly or indirectly hold them accountable for their decisions and actions. Trusted mechanisms for holding each other accountable across hierarchical structures and good employee knowledge of these mechanisms could improve overall outcomes for these hospitals. They could also allow staff to know the proper hierarchical structure, thus letting them adequately identify to whom they should complain whenever suspicious actions are taking place at the hospitals; thus decreasing risks of failures of the governance and management mechanisms.

Difficulties in this research study were primarily based on the difficulty of access to the hospitals. Those who had the power to give access for researchers to do their studies based on the hospital's information, are usually cautious of two main issues: the first is being afraid of the lack of confidentiality, although confidentiality was assured via documents of ethical background; and the second is concern that the researcher may discover hidden weaknesses, hidden forms of corruption, or conflicts of interests that may create turbulence in the daily functioning systems at these hospitals. Other difficulties were related to the difficulty of data collection, primarily through being able to convince the largest amount of targets to fill the survey. Moreover, it was difficult to convince interviewees to be interviewed as they are usually afraid that sensitive

information may be leaked out. These issues may have caused 'statistical or data limitations' where the collected data may have been influenced by those fears, and may not have been the most adequate data that the respondents to the surveys and interviewees would have provided. This in turn may have affected, to a short extent, the significance of results. The research ethics documents including consent forms and information sheets helped in overcoming some of those difficulties of data collection. Moreover, the departure of the CEO during the research process was also a main struggle, leading to a difficulty to retain confidence among hospitals' staff and clinicians during the transition phase where lots of causes for the corporate governance events were still unleashed. Thus, the lack of information on the corporate governance events, and the fact that the events were surprising to many of the participants in this research may be considered as a limitation for this research, affecting the responses of interviewees on questions related to the causes of the events, and thus affecting the resulting analysis of events.

This research study has addresses a gap in the literature regarding the hospital governance in Lebanese settings, specifically in the non-profit private hospitals category. Nevertheless, the results obtained in this study cannot be generalized; they only represent a part of the hospital governance systems in Lebanon, that of the non-profit private hospitals. Results also cannot be generalized to cover all hospitals in this category. However, the originality of this research study lies in studying a congregation of different hospitals with different managements, different locations, different sizes, and many other different specifications; governed by a single congregation with the help of the senior managers of each hospital. This form is a common one for non-profit organisations in Lebanon.

This research may be considered as a building block for future research, where similar surveys to the one used in this research study needs to be further validated in the future with similar and slightly different populations, to ensure it is robust when replicated. Furthermore, it may be interesting if interviews with the same interview schedules are performed and analysed for the same hospitals at a different period. It would also be interesting to replicate this study, changing the target population into different non-profit private hospitals than the ones used for this study. It may also be interesting to perform this study on the

two other types of hospitals in Lebanon: the for-profit private hospitals, and the public/ governmental hospitals. Likewise, to further broaden the target population, the same study may be performed on the same types of hospitals but in different countries, in order to be compared to those performed in the Lebanese settings.

REFERENCES

- Abdullah, H., & Valentine, B. (2009). Fundamental and ethics theories of corporate governance. *Middle Eastern Finance and Economics*, 4(4), 88-96.
- Abid, G., Khan, B., Rafiq, Z., & Ahmed, A. (2014). Theoretical Perspectives of Corporate Governance. *Bulletin of Business and Economics*, 3(4), 166-175.
- About the OECD. Retrieved April 20, 2015, from <http://www.oecd.org/about/>
- Administrative Divisions of Countries "Statoids" (2013, October 29). *Provinces of Lebanon*. Retrieved from <http://www.statoids.com/ulb.html>
- Adrian, A. (2000). Clinical and corporate governance-salvation or just jargon?. *Australian Nursing and Midwifery Journal*, 7(10), 36.
- Agrawal, A., and Knoeber, C. R. (1996). Firm performance and mechanisms to control agency problems between managers and shareholders. *Journal of financial and quantitative analysis*, 31(03), 377-397.
- Aguilera, R. V., Filatotchev, I., Gospel, H., and Jackson, G. (2008). An organisational approach to comparative corporate governance: Costs, contingencies, and complementarities. *Organisation Science*, 19(3), 475-492.
- Aguilera, R. V., and Cuervo-Cazurra, A. (2004). Codes of good governance worldwide: what is the trigger?. *Organisation Studies*, 25(3), 415-443.
- Agency Theory Definition | Investopedia. (2003, November 18). Retrieved April 20, 2015, from <http://www.investopedia.com/terms/a/agencytheory.asp>
- Alexander, J. A., Morrissey, M. A., and Shortell, S. M. (1986). Physician participation in the administration and governance of system and freestanding hospitals: a comparison by type of ownership. *For-profit enterprise in health care*, 402-21.

Archer, M., Bhaskar, R., Collier, A., Lawson, T., and Norrie, A. (2013). Critical realism: Essential readings. *Routledge*.

Argandoña, A. (2011). Stakeholder theory and value creation. *IESE Business School*.

Baker, G. R., Norton, P. G., Flintoft, V., Blais, R., Brown, A., Cox, J., and O'Beirne, M. (2004). The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada. *Canadian medical association journal*, 170(11), 1678-1686.

Baysinger, B. D., and Butler, H. N. (1985). Corporate governance and the board of directors: Performance effects of changes in board composition. *Journal of Law, Economics, and Organisation*, 1(1), 101-124.

Bazeley, P. (1999). The bricoleur with a computer: Piecing together qualitative and quantitative data. *Qualitative Health Research*, 9(2), 279-287.

Bazeley, P. (2002). The evolution of a project involving an integrated analysis of structured qualitative and quantitative data: from N3 to NVivo. *International Journal of Social Research Methodology*, 5(3), 229-243.

Bell, Gareth I. (2013). Restoring trust in the corporation: an interview with Colin Mayer, Peter Moores Professor of Management Studies at Said Business School, and author of Firm Commitment. *Strategic Direction*, 29(6), 35-39.

Berle, A. A., and Means, G. C. (1932), The modern corporation and private property. *New York: Commerce Clearing House*.

Bhaskar, R. (1978). A Realist Theory of Science, Brighton. *Routledge*.

Bhaskar, R. (2008). A realist theory of science. *Oxford Routledge*.

Bhimani, A., and Soonawalla, K. (2005). From conformance to performance: The corporate responsibilities continuum. *Journal of Accounting and Public Policy*, 24(3), 165-174.

- Birch, K., Field, S., Scrivens, E. (2000). *Quality in General Practice*. Radcliffe Publishing.
- Bouton, D. (2002). Promoting better corporate governance in listed companies. *Mouvement des Entreprises de France (MEDEF)*.
- Braithwaite, J., and Travaglia, J. F. (2008). An overview of clinical governance policies, practices and initiatives. *Australian Health Review*, 32(1), 10-22.
- Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.
- Brennan, N. M., and Solomon, J. (2008). Corporate governance, accountability and mechanisms of accountability: an overview. *Accounting, Auditing and Accountability Journal*, 21(7), 885-906.
- Bryman, A. (2004) *Social Research Methods* (2nd edition). Oxford: Oxford University Press.
- Buetow, S. A., and Roland, M. (1999). Clinical governance: bridging the gap between managerial and clinical approaches to quality of care. *Quality in health care*, 8(3), 184-190.
- Bushman, R. M., Piotroski, J. D., & Smith, A. J. (2004). What determines corporate transparency?. *Journal of accounting research*, 42(2), 207-252.
- Cadbury, A. (1992). Report of the committee on the financial aspects of corporate governance (Vol. 1). Gee.
- Cadbury, A. (1999). What are the trends in corporate governance? How will they impact your company?. *Long Range Planning*, 32, 12-19.
- Cadbury, A. (2000). The corporate governance agenda. *Corporate Governance*, 8(1), 7-15.
- Campbell, D. T., and Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological bulletin*, 56(2), 81.

Charitou, A., Georgiou, I., and Soteriou, A. C. (2017). Corporate Governance, Board Composition, Director Expertise, and Value: The Case of Quality Excellence. *Multinational Finance Journal*.

Cheffins, B. (2001). History and the global corporate governance revolution: the UK perspective. *Business History*, 43(4), 87-118.

Cheffins, B. R. (2013). The history of corporate governance. *Oxford handbook of corporate governance*.

Chen, C. X., Lu, H., and Sougiannis, T. (2012). The Agency Problem, Corporate Governance, and the Asymmetrical Behaviour of Selling, General, and Administrative Costs*. *Contemporary Accounting Research*, 29(1), 252-282.

Cheng, T. C. E., Yip, F. K., and Yeung, A. C. L. (2012). Supply risk management via guanxi in the Chinese business context: the buyer's perspective. *International Journal of Production Economics*, 139(1), 3-13.

Clarke, P. (2003). Towards a greater understanding of the experience of stroke: Integrating quantitative and qualitative methods. *Journal of Aging studies*, 17(2), 171-187.

Clarke, T. (2004). Theories of corporate governance. *The Philosophical Foundations of Corporate Governance*, Oxon.

Claessens, S. (2003). Corporate Governance and Development. *Global Corporate Governance Forum. Focus 1*.

Claessens, S. (2006). Corporate governance and development. *The World Bank Research Observer*, 21(1), 91-122.

Claessens, S., and Yurtoglu, B. B. (2013). Corporate governance in emerging markets: A survey. *Emerging markets review*, 15, 1-33.

Clark, G. (2001). The secret history of the Industrial Revolution. *Manuscript, University of California, Davis*. Available at <http://www.econ.ucdavis.edu>.

Code, C. (2003). The combined code on corporate governance. *Financial Reporting Council. London.*

Cohen, J., Ding, Y., Lesage, C., and Stolowy, H. (2012). Corporate fraud and managers' behaviour: Evidence from the press. *Entrepreneurship, Governance and Ethics* (pp. 271-315). *Springer Netherlands.*

Cooper, S. J. (2008). From Claude Bernard to Walter Cannon. Emergence of the concept of homeostasis. *Appetite*, 51(3), 419-427.

Core, J. E., Holthausen, R. W., and Larcker, D. F. (1999). Corporate governance, chief executive officer compensation, and firm performance. *Journal of financial economics*, 51(3), 371-406.

Corporate Governance Committee. (1997). The Dutch Corporate Governance Code: Principles of good corporate governance and best practice provisions. *Corporate Governance Committee.*

Council, A. C. G. (2003). Principles of good corporate governance and best practice recommendations. *Australian Stock Exchange Limited.*

Council, F. R. (2008). Guidance on audit committees. *London: FRC. Available at: <http://www.frc.org.uk/getattachment/6ec23196-28ee-406e-8f56-89ab9d1dc06d/Guidance-on-Audit-Committees-September-2012.aspx>.*

Crow, P., Lockhart, J., and Lewis, K. (2013, January). The relationship between governance and performance: Literature review reveals new insights. In *ECMLG2013-Proceedings For the 9th European Conference on Management Leadership and Governance: ECMLG 2013* (p. 35). Academic Conferences Limited.

Crow, P. R., and Lockhart, J. C. (2014). On the use of critical realism to advance governance research beyond correlations. *Proceedings of the British Academy of Management Conference 2014 (in press).*

Dalton, D. R., Daily, C. M., Certo, S. T., and Roengpitya, R. (2003). Meta-analyses of financial performance and equity: fusion or confusion?. *Academy of Management Journal*, 46(1), 13-26.

Daily, C. M., Dalton, D. R., and Cannella, A. A. (2003). Corporate governance: Decades of dialogue and data. *Academy of management review*, 28(3), 371-382.

Davis, G. F., and Cobb, J. A. (2010). Resource dependence theory: Past and future. *Research in the Sociology of Organisations*, 28(1), 21-42.

Davis, J. H., Schoorman, F. D., and Donaldson, L. (1997). Toward a stewardship theory of management. *Academy of Management review*, 22(1), 20-47.

Definition of corporation in English. Retrieved April 20, 2015, from <http://www.oxforddictionaries.com/definition/english/corporation>

Denis, D. K. (2001). Twenty-five years of corporate governance research... and counting. *Review of financial economics*, 10(3), 191-212.

Denis, D. K., and McConnell, J. J. (2003). International corporate governance. *Journal of financial and quantitative analysis*, 38(01), 1-36.

Denzin, N. K., and Giardina, M. D. (2008). Qualitative inquiry and the politics of evidence. *Left Coast Press*.

Dewey, J. (1994). The moral writings of John Dewey. *Pyr Books*.

DeZoort, F. T., and Salterio, S. E. (2001). The effects of corporate governance experience and financial-reporting and audit knowledge on audit committee members' judgments. *Auditing: A Journal of Practice & Theory*, 20(2), 31-47.

DiStefano, C., Zhu, M., and Mindrila, D. (2009). Understanding and using factor scores: Considerations for the applied researcher. *Practical Assessment, Research and Evaluation*, 14(20), 1-11.

Djellal, F., and Gallouj, F. (2005). Mapping innovation dynamics in hospitals. *Research Policy*, 34(6), 817-835.

Donabedian, A., Wheeler, J. R., and Wyszewianski, L. (1982). Quality, cost, and health: an integrative model. *Medical care*, 975-992.

Donaldson, L. J., and Gray, J. A. (1998). Clinical governance: a quality duty for health organisations. *Quality in health care: QHC*, 7, S37-44.

Donaldson, L. J., and Donaldson, R. J. (2003). Essential public health. *Radcliffe Publishing*.

Donaldson, L., and Davis, J. H. (1989). CEO governance and shareholder returns: Agency theory or stewardship theory. *Australian graduate School of Management, University of New South Wales*.

Donaldson, L., and Davis, J. H. (1991). Stewardship theory or agency theory: CEO governance and shareholder returns. *Australian Journal of management*, 16(1), 49-64.

Donaldson, T., and Preston, L. E. (1995). The stakeholder theory of the corporation: Concepts, evidence, and implications. *Academy of management Review*, 20(1), 65-91.

Downward, P., and Mearman, A. (2002). Critical realism and econometrics: constructive dialogue with Post Keynesian economics. *Metroeconomica*, 53(4), 391-415.

Downward, P., and Mearman, A. (2007). Retrodution as mixed-methods triangulation in economic research: reorienting economics into social science. *Cambridge Journal of Economics*, 31(1), 77-99.

Drezner, D. W. (2012). The irony of global economic governance: The system worked. *Council on Foreign Relations Working Paper [online]*. Available from: http://i.cfr.org/content/publications/attachments/IIGG_WorkingPaper9.

Eeckloo, K., Van Herck, G., Van Hulle, C., and Vleugels, A. (2004). From Corporate Governance To Hospital Governance.: Authority, transparency and accountability of Belgian non-profit hospitals' board and management. *Health Policy*, 68(1), 1-15.

Eeckloo, K., Delesie, L., and Vleugels, A. (2007). Where is the pilot? The changing shapes of governance in the European hospital sector. *The journal of the Royal Society for the promotion of health*, 127(2), 78-86.

Eisenhardt, K. M. (1989). Agency theory: An assessment and review. *Academy of management review*, 14(1), 57-74.

Eldenburg, L., Hermalin, B. E., Weisbach, M. S., and Wosinska, M. (2001). Hospital governance, performance objectives, and organisational form (No. w8201). *National Bureau of Economic Research*.

Epetimehin, F. M. (2013). Impact of risk appetite on the value of a firm. *European Scientific Journal*, 9(22).

Erickson, M. (2002). Science as a vocation in the 21st Century: an empirical study of science researchers. *Max Weber Studies*, 3(1), 33-55.

Fabes R. M. (2002). Toronto Stock Exchange Requests for Comments. Corporate Governance Policy. Proposed new Disclosure Requirement and Amended Guidelines. *Toronto Stock Exchange*.

Faggiolani, C. (2011). Perceived identity: applying grounded theory in libraries. *JLIS.it*, 2(1).

Farrar, J. (2008). *Corporate governance: theories, principles and practice*. Oxford University Press.

Farrokhi, F., and Mahmoudi-Hamidabad, A. (2012). Rethinking convenience sampling: Defining quality criteria. *Theory and practice in language studies*, 2(4), 784.

Faculti. (2014, April 28). *Critical Realism - Roy Bhaskar* [Video File]. Retrieved from <https://www.youtube.com/watch?v=TO4FaaVy0Is&t=45s>

Fielding, J. L., & Fielding, N. G. (2008). Synergy and synthesis: Integrating qualitative and quantitative data.

Fielding, N. G. (2012). Triangulation and mixed methods designs data integration with new research technologies. *Journal of Mixed Methods Research*, 6(2), 124-136.

Ficenech, J. (2014, July 28). Shareholder spring crushed as executive pay soars. *The Telegraph*. Retrieved March 23, 2015, from <http://www.telegraph.co.uk/finance/markets/questor/10994693/Shareholder-spring-crushed-as-executive-pay-soars.html>

Filatovchev, I., and Wright, M. (2011). Agency perspectives on corporate governance of multinational enterprises. *Journal of Management Studies*, 48(2), 471-486.

Financial Crisis Inquiry Commission, and United States. Financial Crisis Inquiry Commission. (2011). *The financial crisis inquiry report: Final report of the national commission on the causes of the financial and economic crisis in the United States*.

Flynn, R. (2002). Clinical governance and governmentality. *Health, Risk and Society*, 4(2), 155-173.

Football Governance Research Centre. Recognized centre of Birbeck, University of London. Retrieved June 10, 2015, from www.football-research.org

Foss, C., and Ellefsen, B. (2002). The value of combining qualitative and quantitative approaches in nursing research by means of method triangulation. *Journal of advanced nursing*, 40(2), 242-248.

Freeman, R. E. (1984). *Strategic Management: A Stakeholder Approach*, Boston, Pitman. Friedman, M. (1970) 'The Social Responsibility of Business Is to Increase Its Profits'. *The New York Times*.

Freeman, R. E. (2010). *Strategic management: A stakeholder approach*. *Cambridge University Press*.

Garvey, G. and Swan, P. (1992), The interaction between financial and employment contracts: a model of Japanese corporate governance. *Journal of the Japanese and International Economics*, Vol. 6..247-74.

Geithner, T., and Summers, L. (2009). A new financial foundation. *Washington Post*, 15.

Gill, A. (2008). Corporate governance as social responsibility: A research agenda. *Berkeley J. Int'l L.*, 26, 452.

Gill, P., Stewart, K., Treasure, E., and Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British dental journal*, 204(6), 291-295.

Gillan, S., and Starks, L. T. (1998). A survey of shareholder activism: Motivation and empirical evidence. *Available at SSRN 663523*.

Gillan, S. L. (2006). Recent developments in corporate governance: An overview. *Journal of corporate finance*, 12(3), 381-402.

Glaser, B., and Strauss, A. (1967). *The Discovery of Grounded Theory: strategies for qualitative research* (Chicago, IL, AVC). *Glaser The Discovery of Grounded Theory: strategies for qualitative research 1967*.

Glaser, B. G., and Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research*. *Transaction publishers*.

Glouberman, S., and Mintzberg, H. (2001-a). Managing the care of health and the cure of disease—Part I: Differentiation. *Health care management review*, 26(1), 56-69.

Glouberman, S., and Mintzberg, H. (2001-b). Managing the care of health and the cure of disease—Part II: Integration. *Health care management review*, 26(1), 70-84.

Gompers, P. A., Ishii, J. L., and Metrick, A. (2001). Corporate governance and equity prices (No. w8449). *National bureau of economic research*.

Grant, G. H. (2003). The evolution of corporate governance and its impact on modern corporate America. *Management Decision*, 41(9), 923-934.

Greene, J. C., Caracelli, V. J., and Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational evaluation and policy analysis*, 11(3), 255-274.

Greene, J., Benjamin, L. and Goodyear, L. (2001) 'The Merits of Mixing Methods in Evaluation', *Evaluation* 7(1): 25–44.

Grosser, K., and Moon, J. (2005). Gender mainstreaming and corporate social responsibility: Reporting workplace issues. *Journal of Business Ethics*, 62(4), 327-340.

Haynes, P. (2003). Managing complexity in the public services. *Open University Press*.

Greenbury, R. (1995). Greenbury report—Director's remuneration—report of a study group. *London, GEE*.

Haleblian, J., Devers, C. E., McNamara, G., Carpenter, M. A., and Davison, R. B. (2009). Taking stock of what we know about mergers and acquisitions: A review and research agenda. *Journal of Management*.

Halligan, A., and Donaldson, L. (2001). Implementing clinical governance: turning vision into reality. *British Medical Journal*, 322(7299), 1413.

Hambrick, D. C., Werder, A. V., and Zajac, E. J. (2008). New directions in corporate governance research. *Organisation Science*, 19(3), 381-385.

Hardt, L. (2009). The history of transaction cost economics and its recent developments. *Erasmus Journal for Economics and Philosophy*, 2(1), 29-51.

Hawley, J. P., and Williams, A. T. (1996). Corporate governance in the United States: The rise of fiduciary capitalism. Working Paper. Saint Mary's College of California. *School of Economics and Business Administration*.

Hayton, J. C., Allen, D. G., and Scarpello, V. (2004). Factor retention decisions in exploratory factor analysis: A tutorial on parallel analysis. *Organizational research methods*, 7(2), 191-205.

Herrigel, G. (2006). Corporate governance: History without historians. *Handbook of business history*, 470-497.

Higgs, D. (2003). Review of the role and effectiveness of non-executive directors (pp. 1-120). *London: DTI*.

Hill, C. W., and Jones, T. M. (1992). Stakeholder-agency theory. *Journal of management studies*, 29(2), 131-154.

Hillman, A. J., Cannella, A. A., and Paetzold, R. L. (2000). The resource dependence role of corporate directors: Strategic adaptation of board composition in response to environmental change. *Journal of Management studies*, 37(2), 235-256.

Hillman, A. J., Withers, M. C., and Collins, B. J. (2009). Resource dependence theory: A review. *Journal of management*.

Hirshleifer, D., and Thakor, A. V. (1994). Managerial performance, boards of directors and takeover bidding. *Journal of Corporate Finance*, 1(1), 63-90.

Hughes, O. E. (1998). New public management. In *Public Management and Administration* (pp. 52-80). Macmillan Education UK.

IFC, O. (2009). Practical Guide to Corporate Governance. *Experiences from the Latin American Companies Circle*.

Jamali, D., Safieddine, A. M., and Rabbath, M. (2008). Corporate governance and corporate social responsibility synergies and interrelationships. *Corporate Governance: An International Review*, 16(5), 443-459.

Jamali, D., Hallal, M., and Abdallah, H. (2010). Corporate governance and corporate social responsibility: evidence from the healthcare sector. *Corporate governance*, 10(5), 590-602.

Jensen, M. C., and Meckling, W. H. (1976). Theory of the firm: Managerial behaviour, agency costs and ownership structure. *Journal of financial economics*, 3(4), 305-360.

Jesover, F., and Kirkpatrick, G. (2005). The revised OECD principles of corporate governance and their relevance to non-OECD countries. *Corporate Governance: An International Review*, 13(2), 127-136.

Johnston, R., and Smith, S. P. (2010). *How critical realism clarifies validity issues in theory-testing research: analysis and case*. Acton, Australia: Australian National University Press.

Johnson, J. L., Daily, C. M., and Ellstrand, A. E. (1996). Boards of directors: A review and research agenda. *Journal of Management*, 22(3), 409-438.

Johnson, R. B., and Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational researcher*, 33(7), 14-26.

Jolliffe, I.T. (2002). Principal component analysis and factor analysis. *John Wiley and Sons, Ltd.*, 150-166.

Jones, G. R. (2010). *Organisational theory, design, and change*. Pearson.

John, K., and Senbet, L. W. (1998). Corporate governance and board effectiveness. *Journal of Banking & Finance*, 22(4), 371-403.

Kelle, U. (2001). Sociological explanations between micro and macro and the integration of qualitative and quantitative methods. *Historical Social Research/ Historische Sozialforschung*, 95-117.

King Committee on Corporate Governance, and Institute of Directors (South Africa) (1994). *King Report on Corporate Governance for South Africa, 1994*. Institute of Directors in Southern Africa.

King Committee on Corporate Governance, and Institute of Directors (South Africa) (2002). *King Report on Corporate Governance for South Africa, 2002*. *Institute of Directors in Southern Africa*.

King Committee on Corporate Governance, and Institute of Directors (South Africa) (2009). *King Report on Corporate Governance for South Africa, 2009*. *Institute of Directors in Southern Africa*.

Klapper, L. F., and Love, I. (2004). Corporate governance, investor protection, and performance in emerging markets. *Journal of corporate Finance*, 10(5), 703-728.

Klein, A. (2002). Audit committee, board of director characteristics, and earnings management. *Journal of accounting and economics*, 33(3), 375-400.

Kostyuk, A., and Braendle, U. (2007). *Corporate governance*. Sample chapter 1, Sumy, Ukraine: Virtus Interpress. Retrieved from http://virtusinterpress.org/additional_files/book_corp_govern/sample_chapter01.pdf

Kozarzewski, P. (2006). Privatization and corporate governance in Poland: Problems and trends. *Available at SSRN 1016055*.

La Porta, R., Lopez-de-Silanes, F., Shleifer, A., and Vishny, R. (2000). Investor protection and corporate governance. *Journal of financial economics*, 58(1), 3-27.

La Porta, R., Lopez-De-Silanes, F., Shleifer, A., & Vishny, R. (2002). Investor protection and corporate valuation. *The journal of finance*, 57(3), 1147-1170.

Langley, L. L. (Ed.). (1973). *Homeostasis: origins of the concept*. Dowden, Hutchinson and Ross.

Lawson, T. (1997). *Economics and reality*. Routledge.

Lazonick, W., and O'sullivan, M. (2000). Maximizing shareholder value: a new ideology for corporate governance. *Economy and society*, 29(1), 13-35.

Lowe, S. (2013). FTSE 350 Corporate Governance Review 2013. Retrieved March 23, 2015, from <http://www.grant-thornton.co.uk/Documents/FTSE-350-Corporate-Governance-Review-2013.pdf>

Leung, S. O. (2011). A comparison of psychometric properties and normality in 4-, 5-, 6, and 11-point Likert scales. *Journal of Social Service Research*, 37(4), 412-421.

Lynch-Fannon, I. (2003). *Working Within Two Kinds of Capitalism: Corporate Governance and Employee Stakeholding: US and EC Perspectives*. Hart Publishing.

Lynn Jr, L. E., Heinrich, C. J., and Hill, C. J. (2001). *Improving governance: A new logic for empirical research*. Georgetown University Press.

Mathiesen, H. (2002). What is Corporate Governance? www.encycogov.com

Mannion, R., and Davies, H. (2002). A principal-agent perspective on clinical governance. *Getting Health Economics into Practice*, Radcliffe Medical Press, Oxford, 67-78.

Markham, J. W. (2006). A financial history of modern US corporate scandals: From Enron to reform. *ME Sharpe*.

Mayer, C. (2013). Firm Commitment: why the corporation is failing us and how to restore trust in it. *Oxford University Press: Oxford*.

Mayer, C. (2013). Why are we facing a crisis of trust in corporations? Retrieved April 10, 2015, from <https://www.youtube.com/watch?v=u1WU2G9M31I>

McGee, R. W., and Yuan, X. (2008). Corporate governance and the timeliness of financial reporting: an empirical study of the people's republic of China.

Mitnick, B. M. (2013). Origin of the theory of agency: an account by one of the theory's originators. *Available at SSRN 1020378*.

Morrissey, D. J. (1989). Toward a new/old theory of corporate social responsibility. *Syracuse Law Review*, 40(3).

Mudambi, R., and Pedersen, T. (2007). Agency theory and resource dependency theory: complementary explanations for subsidiary power in multinational corporations. *Bridging IB theories, constructs, and methods across cultures and social sciences*. Basingstoke: Palgrave Macmillan.

IGSPS (2012). National Health Statistics Report in Lebanon. Retrieved October 15, 2015, from www.igsp.usj.edu.lb/docs/recherche/recueil12en.pdf

Maeda, H. (2015). Response option configuration of online administered Likert scales. *International Journal of Social Research Methodology*, 18(1), 15-26.

Maxwell, J. A. (2012). A realist approach for qualitative research. *Sage Publications*.

McKee, M., and Healy, J. (Eds.). (2002). Hospitals in a changing Europe (Vol. 3). *Buckingham: Open University Press*.

Mingers, J. (2004). Real-izing information systems: critical realism as an underpinning philosophy for information systems. *Information and organisation*, 14(2), 87-103.

Ministry of Environment/ LEDO (2001). Lebanon State of the Environment Report. Retrieved October 15, 2015, from http://www.unep.org/dewa/westasia/Assessments/national_SOEs/west%20asia/Lebanon/Chap1Population.pdf

Ministry of Public Health- Lebanon (2015). List of private hospitals in Mount Lebanon. Retrieved October 22, 2015, from <http://www.moph.gov.lb/MedicalCare/Pages/HealthCareCenter.aspx>

Ministry of Public Health (2013). Statistical Bulletin 2013. Retrieved October 15, 2015, from <http://www.moph.gov.lb/Statistics/Documents/StatisticalBulletin2013.pdf>

Ministry of Public Health (2016). Lists of Lebanese Hospitals. Retrieved January 10, 2016, from <http://www.moph.gov.lb/MedicalCare/Pages/HealthCareCenter.aspx>

Moran-Ellis, J., Alexander, V. D., Cronin, A., Dickinson, M., Fielding, J., Sloney, J., and Thomas, H. (2006). Triangulation and integration: processes, claims and implications. *Qualitative research*, 6(1), 45-59.

Morgan, G., Gregory, F., and Roach, C. (1997). Images of organization. *Sage Publications*.

Mudambi, R., and Navarra, P. (2004). Is knowledge power? Knowledge flows, subsidiary power and rent-seeking within MNCs. *Journal of International Business Studies*, 35(5), 385-406.

Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches* (6thed.). Pearson

Nicholls, M. E., Orr, C. A., Okubo, M., and Loftus, A. (2006). Satisfaction Guaranteed The Effect of Spatial Biases on Responses to Likert Scales. *Psychological Science*, 17(12), 1027-1028.

Nicholls, S., Cullen, R., O'Neill, S., and Halligan, A. (2000). Clinical governance: its origins and its foundations. *British Journal of Clinical Governance*, 5(3), 172-178.

Norwani, N. M., Zam, Z. M., and Chek, I. T. (2011). Corporate Governance Failure And Its Impact On Financial Reporting Within Chosen Companies. *International Journal of Business and Social Science*, 2(21).

Obama, B. (2009). Remarks by the President on 21st century financial regulatory reform. *Initial speech: June, 17, 2009*.

Olson, J. F., and Wright, A. (2015). The Nominating and Corporate Governance Committee. *Corporate Governance: Law and Practice*, 1.

Organisation for Economic Co-operation and Development.(1999). *OECD principles of corporate governance*. OECD.

Organisation for Economic Co-operation and Development (2004). *OECD principles of corporate governance*. OECD.

[Oxford Conversations](https://www.youtube.com/watch?v=6SPUklxrQmU). (2016, December 9). *Bhaskar's 'critical realism' and multiple levels of reality* [Video File]. Retrieved from <https://www.youtube.com/watch?v=6SPUklxrQmU>

Oxford dictionaries (2015) Definition of integrate in English. Retrieved October 20, 2015, from <http://www.oxforddictionaries.com/definition/english/integrate>

Oxford online dictionary. Definition of steward in English. Retrieved April 8, 2015, from <http://www.oxforddictionaries.com/definition/english/steward>

Perrini, F. (2006). Developing corporate social responsibility: A European perspective. *Edward Elgar Publishing*.

Pfeffer, J., and Moore, W. L. (1980). Power in university budgeting: A replication and extension. *Administrative Science Quarterly*, 637-653.

Phillips, D. C. (1987). Philosophy, science and social inquiry: Contemporary methodological controversies in social science and related applied fields of research. *Pergamon Press*.

Piketty, T. (2013). Capital in the Twenty-First Century, Arthur. Goldhammer. *Trans. Cambridge, MA: Harvard University Press*.

Post, J. E., Preston, L. E., and Sachs, S. (2002). Managing the extended enterprise: The new stakeholder view. *California management review*, 45(1), 6-28.

Pound, J. (1993). Creating relationship institutional investors and corporations: A proposal to restore balance in the American corporate governance process. *Columbia University Law School's Centre for Law and Economic Studies' Conference on Relationship Investing: possibilities, patterns and problems, New York Hilton, May,6-7*.

Preker, A. S., and Harding, A. (Eds.). (2003). Innovations in health service delivery: the corporatization of public hospitals (Vol. 434). *World Bank Publications*.

Provan, K. G., and Kenis, P. (2008). Modes of network governance: Structure, management, and effectiveness. *Journal of public administration research and theory*, 18(2), 229-252.

Punch, K. F. (2013). Introduction to social research: Quantitative and qualitative approaches. *Sage Publications*.

Ritchie, J., Lewis, J., Nicholls, C. M., and Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage Publications.

Rodan, S., and Galunic, C. (2004). More than network structure: How knowledge heterogeneity influences managerial performance and innovativeness. *Strategic management journal*, 25(6), 541-562.

Rosam, I., and Peddle, R. (2004). Implementing effective corporate social responsibility and corporate governance: a guide. *British Standards Institution*.

Ross, S.A., Westerfield, R.W., Jaffe, J., (2005). *Corporate Finance*, 7th edition. McGraw Hill Irwin, New York.

Runciman, B., and Walton, M. (2007). *Safety and ethics in healthcare: a guide to getting it right*. Ashgate Publishing, Ltd..

Rutteman Working Group. (1994). *Internal Control and Financial Reporting: Guidance for directors of listed companies registered in the UK*. ICAEW.

Salancik, G. R., and Pfeffer, J. (1978). Who gets power-and how they hold on to it: A strategic-contingency model of power. *Organisational dynamics*, 5(3), 3-21.

Sapir, Edward. "The status of linguistics as a science." *Language* (1929): 207-214.

Sarbanes, P. (2002, July). Sarbanes-oxley act of 2002. In *The Public Company Accounting Reform and Investor Protection Act*. Washington DC: US Congress.

Scally, G., and Donaldson, L. J. (1998). Clinical governance and the drive for quality improvement in the new NHS in England. *Bmj*, 317(7150), 61-65.

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Sage Publications, Inc.

Shleifer, A., and Vishny, R. W. (1997). A survey of corporate governance. *The journal of finance*, 52(2), 737-783.

Smith, R. (2003). Audit committees combined code guidance. *London: Financial Reporting Council*.

SorinNicolae, B., and Monica Violeta, A. (2013). Theories of corporate governance. *Studia Universitatis Vasile Goldiș, Arad-Seria Științe Economice*, (1), 117-128.

Stiglitz, J. E. (2010). Freefall: America, free markets, and the sinking of the world economy. *WW Norton and Company*.

Strauss, A., and Corbin, J. (1990). Basics of qualitative research (Vol. 15). *Newbury Park, CA: Sage*.

Syndicate of hospitals in Lebanon (2015). Liste des hopitaux prived du Liban. *Syndicat des hopitaux du Liban*.

Thompson, B. (2004). Exploratory and confirmatory factor analysis: Understanding concepts and applications. *American Psychological Association*.

Thornton, G. (2003). FTSE 350 corporate governance review. *Grant Thorn (ton Risk Management Services, London*.

Travaglia, J. F., Debono, D., Spigelman, A. D., & Braithwaite, J. (2011). Clinical governance: a review of key concepts in the literature. *Clinical Governance: An International Journal*, 16(1), 62-77.

Treasury, U. S. (2009). Financial regulatory reform: a new foundation. *Washington, DC*.

Tricker, R. B., and Tricker, R. I. (2015). Corporate governance: Principles, policies, and practices. *Oxford University Press, USA*.

Tuan, L. T. (2012). Corporate social responsibility, ethics, and corporate governance. *Social Responsibility Journal*, 8(4), 547-560.

University of Brighton (2014). University of Brighton Code of Practice and Regulations for Research Degrees, 2014/15

Venkatesh, V., Brown, S. A., and Bala, H. (2013). Bridging the qualitative-quantitative divide: Guidelines for conducting mixed methods research in information systems. *MIS quarterly*, 37(1), 21-54.

Wells, H. "The Birth of Corporate Governance" (2010). *Seattle UL Rev*, 33, 1247-at.

Western Australian Department of Health (2001). Office of Safety and Quality in Health Care. Introduction to clinical governance- a background paper. *Perth*.

White KR. (2000). Hospitals sponsored by the Roman Catholic Church: separate, equal, and distinct? *Milbank Q*, 78(2):213–39

Wilson, R. M., Runciman, W. B., Gibberd, R. W., Harrison, B. T., Newby, L., and Hamilton, J. D. (1995). The quality in Australian health care study. *Medical journal of Australia*, 163(9), 458-471.

Williamson, O. E. (1989). Transaction cost economics. *Handbook of industrial organisation*, 1, 135-182.

Williamson, O. E. (1996). The mechanisms of governance. *Oxford University Press*.

Williamson, O. E. (1998). Transaction cost economics: how it works; where it is headed. *De economist*, 146(1), 23-58.

Wolfensohn, J. (1999). Corporate governance is about promoting corporate fairness, transparency and accountability. *Financial Times*, 21.

Wyatt, M. (2004). A handbook of NGO governance. *Place Published: European Center for Not-for-Profit Law*.

Yusoff, W. F. W., and Alhaji, I. A. (2012). Insight of corporate governance theories. *Journal of Business and Management*, 1(1), 52-63.

Zachariadis, M., Scott, S., and Barrett, M. (2013). Methodological implications of critical realism for mixed-methods research. *Mis Quarterly*, 37(3), 855-879.

Zahra, S. A., and Pearce, J. A. (1989). Boards of directors and corporate financial performance: A review and integrative model. *Journal of management*, 15(2), 291-334.

Zeckhauser, R. J., and Pratt, J. W. (1985). Principals and Agents: The Structure of Business. *Boston: Harvard Business School*.

Zingales, L. (1998). Corporate Governance. *The New Palgrave Dictionary of Economics and the Law*, P. Newman ed.

FIGURES AND TABLES

FIGURES

Figure 2.1	Corporate governance and the balance sheet model of the firm	18
Figure 2.2	The Agency Theory Model	41
Figure 2.3	The Stakeholder Model	44
Figure 2.4	The Stewardship Theory Model	45
Figure 2.5	Four Worlds of the General Hospital	54
Figure 3.1	The retroductive approach of critical realism for knowledge creation	70
Figure 3.2	Hospitals contracting with ministry of public health by province and type	80
Figure 3.3	Private Lebanese Hospitals: For-Profit and Non-Profit hospitals by province and type.....	81
Figure 3.4.	Lebanon corruption index from 2006 to 2016.....	83
Figure 3.5.	Lebanon corruption rank from 2006 to 2016.....	84
Figure 3.6	Job in each hospital versus job in hospitals in general	86
Figure 3.7	The four major unidirectional response options in Likert scale	89
Figure 4.1	Factor Analysis Scree Plot	122
Figure 4.2	Mean plot for perception of hospital governance score: comparison between current roles at hospitals	136
Figure 4.3	Mean plot for score comparison between hospital names variables	139
Figure 4.4	Mean plot for score comparison between managerial roles variables	141
Figure 4.5	Mean plot for score comparison between management experience variables	142
Figure 4.6	Mean plot for score comparison between leadership role variables	143

Figure 4.7	Mean plot for score comparison between management education variables	146
Figure 4.8	Mean plot for score comparison between years of work at the hospital variables	148
Figure 5.1	Hierarchal structure of the three hospitals under study	155
Figure 6.1	Diagram of External Stakeholders Described in Interviews	210

TABLES

Table 3.1	The stratified ontology of critical realism	69
Table 3.2	Instrumentation for the data collection tools.....	85
Table 3.3	Full list of how research questions and key concepts link to questionnaire statements	91
Table 3.4.	Interview participants according to role and hospital	105
Table 4.1	Descriptive Statistics for demographic variables	113
Table 4.2	Descriptive Statistics for statements	114
Table 4.3	Frequencies for managerial role.....	115
Table 4.4	Frequencies for management experience	115
Table 4.5	Frequencies for leadership role.....	116
Table 4.6	Frequencies for gender groups	116
Table 4.7	Frequencies for age groups.....	116
Table 4.8	Frequencies for management education	117
Table 4.9	Frequencies for roles at the hospital	117
Table 4.10	Frequencies for years of work at the hospital	117
Table 4.11	Frequencies for distribution of respondents to hospitals	118
Table 4.12	Principal Component Analysis Total Variance Explained	121
Table 4.13	Component Matrix	124
Table 4.14	Communalities	125
Table 4.15	Parallel Analysis to check valid number of components from Factor Analysis	127

Table 4.16	Principal Components Analysis: demonstrating the first general component: perceptions of hospital governance with 16 out of 31 statement items included	130
Table 4.17	Monte Carlo confirmation of 16 item first principal component	131
Table 4.18	Principal Component: General perception of Hospital Governance	133
Table 4.19	Descriptives of the Current Role at the Hospital independent variable compared the dependent variable scores	134
Table 4.20	Multiple Comparisons: employment role and mean score for perception of hospital governance	135
Table 4.21	Descriptives of Gender compared with the dependent variable scores	136
Table 4.22	Descriptives of the Age groups compared with the dependent variable scores	137
Table 4.23	Descriptives of the three hospitals compared with the dependent variable scores	138
Table 4.24	Multiple Comparisons: hospital where you work and mean score for the perception of hospital governance	139
Table 4.25	Descriptives of Management Education independent variable compared with the dependent variable scores	144
Table 4.26	Multiple Comparisons	145
Table 4.27	Descriptives of the years of work at the hospital independent variable compared with the dependent variable scores	146
Table 4.28	Multiple Comparisons: time working and mean score for perception of hospital governance	147
Table 5.1	Methods of performance measurements at each of the three hospitals.....	162
Table 6.1	Responses to qualitative interview questions on control	193

APPENDIX

1. Participant Information Sheet: Quantitative Questionnaire

UNIVERSITY OF BRIGHTON

UNITED KINGDOM

**Hospital Governance in Lebanon: Corporate and Clinical
governance in Non-Profit Private Hospitals**

Participant Information Sheet: Quantitative Questionnaire

- This questionnaire is part of a research project done by myself, Joseph Nasr, a PhD student at the University of Brighton, United Kingdom. This project focuses on hospital governance in Lebanese hospitals.
- The purpose of this study is to contribute to the knowledge of hospital governance in Lebanon, in order to aid the improvement of the Lebanese health sector. I would be grateful if you could assist me by filling in the questionnaire attached.
- I would like you to fill in this questionnaire related to the governance in the hospital you are working in, in order to help me learn more about your experience and to understand how management and governance of the hospital are carried out.
- The questionnaire replies will be anonymous and confidential. You are not required to give your name and address and therefore it is not necessary to record such personal information on the resulting database. Completed questionnaires will be stored in a safe place and destroyed at the end of the research.

- Completion of the questionnaire is completely voluntary, and you are free to withdraw at any time during the process.
- The results of the questionnaire will be analysed to contribute to my PhD research that considers the governance and management of hospitals in the Lebanese Health Sector. It is my aim to eventually publish the results in my thesis and possibly other publications.
- If you find that you have any concerns about this research project, please feel free to contact:

My contact details:

Joseph Nasr Email: joseph@nasrlb.com

Mobile numbers: Lebanon: 961.3107133

United Kingdom: 44.7866199382

Independent contact details:

Professor Philip Haynes. Head of the School, Applied Social Science at the University of Brighton, Falmer campus. Email: P.Haynes@brighton.ac.uk

Doctor Mary Darking. Course Leader for the Masters in Public Administration at the University of Brighton, Falmer campus. Email: M.L.Darking@brighton.ac.uk

2. Participant Information Sheet: Semi-Structured Interviews

UNIVERSITY OF BRIGHTON

UNITED KINGDOM

**Hospital Governance in Lebanon: Corporate and Clinical
governance in Non-Profit Private Hospitals**

Participant Information Sheet: Semi-Structured Interviews

- These interviews are part of a research project done by myself, Joseph Nasr, a PhD student at the University of Brighton, United Kingdom. This project focuses on hospital governance in Lebanese hospitals.
- The purpose of this study is to contribute to the knowledge of the hospital governance in Lebanon, in order to aid in the improvement of the Lebanese health sector. I would be grateful if you could assist me by taking part in the interview.
- The aim of these in depth interviews is to elicit your views of managers and senior staff about the governance in the hospital you are working in, in order to help me learn more about comparative governance and management practices in the Lebanon and to acquire detailed data about how governance acts in this hospital.
- I am seeking your agreement to tape record the interview so that I have an accurate record of what is said. The tapes will be stored in secure and locked facility during the period of this research study and destroyed after transcription and at the end of my research project.

- The interview is confidential and anonymized. No personal information such as name and address will be recorded. I will seek to conceal the identity of each individual hospital and its departments, as their names will be anonymized in my write up and any resulting publication. There may be a small risk that someone reading any resulting publication that has a detailed knowledge of the Lebanese health sector can speculate which hospital I am referring to, but they are unlikely to be able to do this with a high degree of authority and confidence.
- The person being interviewed is expected to keep the interview(s) confidential for personal and research purposes, thereby protecting both themselves and my research from any negative consequences.
- There will be only one condition where confidentiality will be broken. This is when I discover patient harm, past or intended, and that can or should have been avoided. It is my duty then to refer the person/people responsible for this harm to the relevant quality and safety manager of that hospital.
- Taking part in this interview is completely voluntary, and you are free to withdraw at any time during the process.
- The results of this research will be used only for PhD research purposes and any publications that result from my PhD.
- This research proposal and design has been subject to the research ethics and governance requirements of the University of Brighton where my PhD is being supervised and examined.
- If you find that you have any concerns about this research project, please feel free to ask me or to contact:

My contact details:

Joseph Nasr

Email: joseph@nasrlb.com

Address 1: Villa Antoine Nasr, Muzar Street, Ghazir- Lebanon. Mobile number: 961.3107133

Address 2: 36 Penywern Road, Earls Court, London- United Kingdom. Mobile number: 44.7866199382

Independent contact details:

Professor Philip Haynes. Head of the School Applied Social Science at the University of Brighton, Falmer campus. Email:

P.Haynes@brighton.ac.uk

Doctor Mary Darking. Course Leader for the Masters in Public Administration at the University of Brighton, Falmer campus. Email:

M.L.Darking@brighton.ac.uk

3. Participant Consent Form: Semi Structured Interviews

UNIVERSITY OF BRIGHTON

UNITED KINGDOM

**Hospital Governance in Lebanon: Corporate and Clinical
governance in Non-Profit Private Hospitals**

Participant Consent Form: Semi Structured Interviews

- I agree to take part in this research and to therefore contribute to the knowledge in Lebanese hospital management and governance, aiming to further improve the Lebanese health sector.
- The researcher has explained to my satisfaction the purpose of the research and I have read and understood the information sheet (Lebanese Hospital Governance-Interview PIS V1). I fully understand the purpose of the research and the procedures that will be used.
- I am aware that I will be required to answer questions in relation to my experiences of governance and management practices and regarding my position in the hospital.
- I understand that the resulting data will be anonymized so that I am not identified by name and address and that the researcher will also undertake to anonymize the department and hospital identity in any resulting write up and publication, although there is potentially a small risk that a reader might be able to speculate about what hospital is being referred to.
- I understand that all data collected for research purposes in the form of paper copies and recordings will be destroyed after the research is complete.

- I am aware that the interview will be audio-recorded and agree to being audio-recorded.
- I understand that I am free to withdraw from the investigation at any time without giving reasons for doing so.

Name (please print)

.....
.....

Date

.....
.....

Signature

.....
.....

4. Ethics and governance of the research project: Comments of the committee and clarifications

On the 23rd of March, 2015 the first list of comments of the committee were received and were clarified with a reply on the 14th of April, 2015, after being discussed with my supervisors. The raised issues by the committee were addressed as follows:

- 1) The committee reviewers needed a confirmation that no patients will be involved in this research, as a 'Yes' was checked by mistake instead of a 'No' for the question "I shall ensure that, where relevant and appropriate, service users and consumers are involved in the research process" of the governance checklist. This was corrected and a corrected version of the governance checklist was sent again to the committee. The committee was also reassured with a reply that no patients are involved in the data collection of my research.

- 2) The committee reviewers suggested that there could be some negative impacts for those involved, as well as broader political impacts. So this issue was resolved by replying to the committee that confidentiality will be reassured to all targets of the study through an information sheet accompanied by a consent form, and that anonymity is chosen to be guaranteed in order to avoid any kind of destabilization of the hospital as a result of the research. The reply also included the issue of whistle blowing: as 'Whistle blowing' is not yet a legal concept used in Lebanon, the staff in Lebanon might not recognise it or understand what it means. Nevertheless, the issue of whistle blowing that might occur while interviewing any of the targets for data collection will be taken into account, and the interview participant information sheets will be adjusted to include that the research will have confidentiality conditions. The interview participant information sheet will clarify that if any information is given about patient harm, past or intended, and that can or should have been avoided, I will be duty bound to inform the relevant quality and safety manager of that hospital. On the other hand, since the questionnaires are filled by confidential respondents and do not include open questions, these questionnaires will not raise any opportunities for a

participant to make allegations of harm, and hence there will be no need to worry about the issue of whistle blowing for the quantitative part of the research.

- 3) The committee reviewers commented on my position regarding the Patient and Public Involvement (PPI) and the perceptions of governance. The reply to the committee included that one of the outcomes of the research will be proposals for improving how patients and public could be involved in hospital governance. Patient and public involvement in governance practice will be mentioned in the discussion and conclusion of the thesis, even though no patients are involved in the data collection. At the end of the study, the existence or absence of the patients' involvement will be documented and recommendations will be made. No piloting will be performed with patient groups because in Lebanon there are no patient groups in general (a different context from the United Kingdom), and because the types of questions are targeted to owners/shareholders, managers and clinicians, and the same questions cannot be targeted to patients. Moreover, patients are less directly aware of the concept of corporate governance.

With respect to the perceptions of governance, the committee was reassured that the study is a theoretical study rather than a study of perceptions. It studies the conceptual basics of governance and how managers and practitioners relate to current conceptual definitions in literature. Thus, it will conclude on the relevance of theoretical concepts to current practice, rather than taking managers' individual perceptions as its starting point.

Along with the response to the committee, the statement: "There will be only one condition where confidentiality will be broken. This is when I discover patient harm, past or intended, and that can or should have been avoided. It is my duty then to refer the person/people responsible for this harm to the relevant quality and safety manager of that hospital" was added both to the research plan and the participant information sheet of the semi-structured interviews.

On the 23rd of April, 2015 the second list of comments of the committee was received and was clarified with a reply on the 2nd of May, 2015, after being

discussed with my supervisors. Few clarifications were needed by the committee as follows: the location of the interviews was clarified to be at the hospitals, in the interviewees' offices. It was also clarified that no one should know that any other individual has taken part in this study. Interviews will be kept confidential. The visits to the interviewees will look like an ordinary external business visit. It was reassured that this will have no negative consequences to anyone because the interviewees will be asked verbally to keep the interviews confidential, in order to protect both themselves and the research from any negative consequences. In order to make the point of confidentiality of the interviews clear, a statement "The person being interviewed is expected to keep the interview(s) confidential for personal and research purposes, thereby protecting both themselves and my research from any negative consequences" was added to the participant information sheet of the semi-structured interviews. It was also clarified that physicians who will be included in my qualitative research study will only be the ones who have managerial roles at the hospital. Examples of these physicians are the heads of departments. Other physicians will be excluded from the research study.

5. Questionnaire

Background Information

1- To what extent do you see yourself having a managerial role on a scale of 1-10 where 1 represents no management role? *

1	2	3	4	5	6	7	8	9	10
<input type="radio"/>									

2- To what extent have you had management experience on a scale of 1-10 where 1 represents no management experience? *

1	2	3	4	5	6	7	8	9	10
<input type="radio"/>									

3- To what extent do you see yourself having a leadership role on a scale of 1-10 where 1 represents no leadership role? *

1	2	3	4	5	6	7	8	9	10
<input type="radio"/>									

4- Gender *

- Male
- Female

5- Age *

- 18-25
- 26-35
- 36-50
- 51 and above

6- Have you had any management education or training?

- Yes - formal and/or certified education or training
- Yes - informal and/or uncertified education or training
- No

7- What is your current role at this hospital? *

Please tick all relevant current roles

- Member of the General Council
- Member of the Board of Directors
- Clinical Manager
- Non Clinical Manager
- Physician

- Licensed Nurse

8- How long have you been working at this hospital *

- 0-5 years
- 6-10 years
- More than 10 years

9- Which hospital do you currently work in *

- Hospital X
- Hospital Y
- Hospital Z

Statements

The remainder of the questionnaire lists statements about hospital governance. Please indicate your level of agreement or disagreement for all of the statements below. Thank you

10- The hospital's General Council should have control over the activities of all hospital managers *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

11- If a serious mistake is made with hospital financial accounting the General Council will hold the relevant manager responsible *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

12- In this hospital all serious clinical errors are investigated appropriately *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

13- Not all hospital managers are responsible for the financial performance of this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

14- The General Council ensures that clinicians (physicians and nurses) are well-paid in order to ensure efficiency and good care in this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

15- It is the responsibility of the General Council to ensure good independent financial audit of this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

16- The Chief Executive Officer (CEO) of this hospital is well paid for the level of responsibility he/she has *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

17- There should be more control over how the Chief Executive Officer (CEO) spends this hospital's money *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

18- All hospital managers should have fixed-term employment contracts which are reviewed and renewed against their performance *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

19- If clinicians (physicians and nurses) develop new clinical procedures that build their own professional status, these may be too risky and expensive for the hospital to support *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

20- It is difficult for hospital managers to prioritize patient safety and quality of patient care *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

21- It is in the interests of the General Council to pay senior managers high salaries *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

22- The Ministry of Public Health has too much influence on this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

23- The Syndicate of Hospitals pays too much attention to achieving benefits for the owners of this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

24- The Lebanese Order of Physicians strongly represents the physicians' interests in this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

25- Patients are able to rely on the law to hold clinicians (physicians and nurses) to account *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

26- I would expect non-profit hospitals to be managed better than private, for-profit hospitals *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

27- It is important for non-profit hospitals to make a surplus of money that can be reinvested *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

28- I would expect at least an occasional visit from a member of the General Council to my department *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

29- Clinical performance of this hospital is managed appropriately through clear reporting *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

30- External factors like politics or the economic situation of the country have too much influence on what happens in this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

31- This hospital is well-organized and efficient *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

32- All managers in this hospital are rewarded adequately for their work *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

33- The General Council does not have enough control over the pay rises of managers *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

34- I am confident that the General Council and the Chief Executive Officer (CEO) have a shared strategic vision for this hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

35- The General Council has the power to direct the Chief Executive Officer (CEO) to act in exceptional circumstances if they see it is for the hospital's benefit *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

36- The Chief Executive Officer (CEO) in this hospital has more power than the General Council *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

37- The Chief Executive Officer (CEO) cannot prioritize his/her personal interests over those of the hospital *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

38-The main objective of the Chief Executive Officer (CEO) is to ensure the hospital makes a surplus of money *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

39- The Chief Executive Officer (CEO) has an appropriate professional background *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

40- The members of the General Council have appropriate professional backgrounds *

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

6. Interview schedule

- What are the main tasks that you are involved in in your day-to-day work at this hospital?
 - Balance of tasks eg management/clinical, or...
 - Who are you responsible for? + Who do you report to?
- Are all your tasks related to internal requirements? Do some of them relate to requirements set by external organisations eg Order of Physicians, Ministry of Health, Syndicate of private hospitals, ...
- Do you think people in this hospital are more focused on internal requirements than external requirements?
- Would you describe this hospital as an efficient hospital? If No, how could it be improved?
- In your opinion, do you see this hospital as being well-organized? If No, how could it be improved?
- Would you describe this hospital as having a good standard of care?
- We all know that errors occur at hospitals. Do you think that errors are dealt with well at this hospital?
- In your opinion, who's responsible for patient care quality and safety?
- Are the systems of reporting clear at this hospital? (Clinical Vs Management reporting)
- Are there any problems with reporting?
- How is the overall performance of the hospital measured (internally) & judged (externally)?
- Are (all) contracts at this hospital renewed according to performance?
- How would you describe the relationship between the management and clinicians?
- Are there good incentives for working at this hospital? What are they?
- Are all staff paid well in this hospital?
- Are the incentives the same for all staff?
- Can you briefly describe the hierarchy in this hospital?
- How is communication across the hierarchy of this hospital carried out? (Visits, Other communications)

- Who would you describe as being in control of this hospital? (Financially? Power? Decision making? Politically?)
- Who do you consider yourself accountable to?
- Is there a shared strategic vision for this hospital? Is it shared by all staff?
- Who is responsible for the financial performance at this hospital?
- Do you see that the senior management, board members, and general council have appropriate professional backgrounds and experience?
- Can the CEO prioritize his personal interests over the interests of the hospital? What prevents them?
- How do you see the future of this hospital?

7. Examples of interview thematic coding

Themes	Colour
Corporate Governance	RED
Clinical Governance	YELLOW
Corporate Governance Events	GREY
External Stakeholders	BLUE
Perception of Hospital Governance	PINK

- What are the main tasks that you are involved in in your day-to-day work at this hospital?

Manager: Hospital X

I come in the morning, I follow up on what happened at night and if there have been any problems at night at the hospital in the medical field, for example if there has been something medically wrong with patients at night; whether physicians checked up on their patients at night or not. Then I check if the different physicians of the different department came to the hospital, were late, or if there are any issues that need to be handled in this area. Then as a physician (heart and vascular surgeon), I do my round to check my patients, and if I have surgeries during the day, I perform them. I also discuss with physicians their daily problems and try to manage accordingly. I also try to do new projects for the hospital.

Manager: Hospital X

As a manager, I have the management and control of employees. I work with making sure that the number of employees in my department suits the required tasks. I also deal with managing the number of places available for patients. I also work on daily basis with nurses. I do the competency tests, personnel evaluation (for new personnel: I evaluate their capabilities), and for old personnel, we do the evaluation once a year. Then, I deal with clinical audit. I also work on abiding by the rules of the accreditation system we are following. I work on informing the personnel on the accreditation system and its updates. I also collaborate and communicate with the 16 personnel responsible of the different floors. We meet every month, and make common decisions. I also do quality improvement plans.

- Are all your tasks related to internal requirements? Or does some of them relate to requirements set by external organisations eg Order of Physicians, Ministry of Health, Syndicate of private hospitals, ...

Manager: Hospital Y

Yes, for sure. For example we present and attend conferences in collaboration with the Order of Physicians. We take points on these conferences (what we call as CMI- “Information Medicale Continue”). Whenever we have to present a conference, we send the CV of the presenter with an abstract for the conference to the Order of Physicians so that we take their agreement and hence get the CMI. So for sure our tasks relate to requirements set by external organisations.

Manager: Hospital Y

I am responsible for the contracts that we have with the National Health Service (known in Lebanon as Social Security) and the Ministry of Health and others. Whenever there are any problems, I deal with them. I meet with these parties. I also collaborate with the president of the hospital for these things. There are some contracts that are renewed every year; these require many documents to be prepared in advance.

Manager: Hospital Y

There are lots of things that are externally related. First of all, the Order of nurses, as I have to implement all their recommendations of things that are related to nursing: I have to implement the new laws related to nursing, I have to stick to the number of hours they can work (42 hours per week), make sure that all nurses working here should be members of the order and have to present their degrees in order to get working permits. Nurses are not allowed to work without this working permit given by the order of nurses. I have to control all the files of the personnel that work under my supervision and management. We also deal with the order of physicians in cases of trainings or conferences. We also deal with the Ministry of health for accreditations. I am now a member

of the group of experts in the **Ministry of Health**. This group works on **reformulating standards**. I am also a member of the **Order of Midwives** as I am also a midwife. So these are commitments that influence this hospital both externally and internally. We also collaborate with **universities**. We are in direct contact to help them in their trainings. **I send them nurses for those trainings**.

Manager: Hospital Z

Mainly, all my tasks are internally related, but, for sure, there are some external (not the order of physicians as I do not have any relation with them) like the **ministry of health**, and this takes place for example whenever the **ministry sends a list of requirements that hospitals must obey**. Same for the **syndicate of hospitals**; and this is **whenever they have trainings which we have to fulfill, or other requirements from their behalf**. I also have external relations with the **ministry of finance** and the **National Health Service**, since I am responsible for the payroll and some of the reports to the National Health Service; so many of the paperwork related to these two entities are part of my responsibilities.

➤ Are all staff paid well in this hospital?

Manager: Hospital X

As employees, I may say that yes, they are well paid in comparison to other hospitals. I asked about salaries in other hospitals. Plus **we are now able again to pay salaries on time, sometimes with a delay of 4-5 days. So now we're back on the track from this aspect; last month's salaries were paid to all employees.**

Manager: Hospital X

No, because **those who get the least salaries are those who deal directly with the patient. So we are asking them to implement lots and lots of conditions and rules and we are expecting a lot of them, and we are giving them very low salaries. This is not fair in a way.**

Manager: Hospital Y

I think most of them are well paid.

- Can you briefly describe the hierarchy in this hospital?

Manager: Hospital X

We have the president, under her we used to have a CEO, then a medical manager, an executive director and a financial manager at the same time, a quality manager, an HR manager, and a nursing manager. Each of these managers has his/her own department. In each of these departments, there are the personnel who have their different roles.

What happened in fact is that the CEO left the hospital due to problems that happened with him. He was replaced by a committee constituted from different people and professionals. This committee is responsible now for the management of the hospital.

- Is there a shared strategic vision for this hospital? Is it shared by all staff?

Manager: Hospital Y

Yes, but I don't think they all know it. I think we should explain the vision more and post it on the floors.

- Can the CEO prioritize his personal interests over the interests of the hospital? What prevents them?

Manager: Hospital Y

I don't have a direct relationship with the CEO, so I cannot answer such question.