Domination and Professional Dominance: Physicians at Grips with Management

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In research on hospital organisations, references to the concept of power can be found thematised by the sociology of organisations or the sociology of contingency. However, these sociologies do little to broach the question of domination. Domination is distinctive from power, which can be defined in terms of capacity to take action, on things or on others, using means that can be incentive or coercive. Public hospitals are characterised by the coexistence of a dual system of authority: the administrative power and the medical power, rooted in expertise. Using 70 semi-directive interviews with hospital directors, we analyse the social representations, points of resistance and appropriation of the reforms by professionals. The members of three professional groups, administrative, medical and health executive, are diverging on the recent or on-going organisational changes. In the medical profession, segmentation is increasing with new hierarchies in which the practitioners find themselves in dominated positions.

Keywords: hospital reforms in France, New Public Management, power, domination, professional dominance, managerial innovation.

Healthcare systems and the hospital as pivot institution are the focus of recurring debate in the public arena. That debate has been stoked by the recent reforms[1] instituted in the field of healthcare, in connection with the New Public Management movement, entailing billing by activity (T2A), new governance (organisation by division, …), and the 2009 HPST Act (Gheorghiu and Moatty 2013). While the domination exercised by the medical authorities long did not come up against any "counter-power", even in the hospital environment, where physicians were initially only visitors, the reforms call into question the balance between the "three powers" commonly referred to within the context of the hospital institution: the medical, the administrative and the nursing. While these powers are not placed at the same level, it is made clear to each that they have their own autonomous, if not equitable, territory within the hospital as institution. When Friedson (Friedson 1970a) introduced the concept of professional dominance, he brought analysis in terms of power or domination back to the fore. The concept lays down the ground for examining the struggle between the "economic power" and "intellectual pow-

er" in terms of shifts within professional groups, in the face of managerial innovation. While clinical physicians in large part are daunted by the prospect that their profession could decline further to a relative decrease in their autonomy, it is important to study how modes of domination and dominance are being transformed within the hospital institution.

Power, domination and professional dominance

In order to analyse the recent shifts in each of the professional groups operating in hospitals, we will mobilise three key concepts: power, domination and professional dominance.

Power and domination in the hospital environment

In research on hospital organisations, references to the concept of power can be found thematised by the sociology of organisations (Crozier 1963) or the sociology of contingency (Mintzberg 1982). However, these sociologies as well as the common sense discourse on hospitals do little to broach the question of domination. Domination is distinctive from power, which can be defined in terms of capacity to take action, on things or on others, using means that can be incentive or coercive. According to Max Weber (Weber 1995 [1921]), relationships of domination go beyond mere power relationships insofar as they are based on processes designed to legitimise social order and thereby enable the construction of consent. In this sense, the power of physicians is not so much the result of their holding any form of hierarchical authority, meaning a subordinating power that would confer their official administrative status on them, but the cognitive authority conferred upon them by their expertise in the medical field. It is important to distinguish institutional authority, which results from status, from the enunciating authority that comes from credibility, i.e., from the fact of having recognised authority in a given field, even where these two forms of authority often maintain relationships of complementarity (Leclerc 1996). Consequently, unlike organisations where the hierarchical line is clearly unequivocal, public hospitals are characterised by the co-existence of a dual system of authority: the administrative power and the medical power, rooted in expertise (Smith 1970).

Domination and professional dominance

The importance of the cognitive authority resulting from expertise explains why the question of relations between professional powers and formal knowledge is central to Eliot Freidson's analysis regarding medical power (Freidson 1986). His work marked a turning point toward the end of the last century, attesting to the transformations in both the profession and the hospital as institution. The professional dominance of physicians casts attention back on the fact that the profession is able to establish and maintain the structurally asymmetrical nature of physician-patient relations over time due to the knowledge gap between the professional and the layman (Freidson 1970a). Freidson had observed that legitimate deviance (subject to condition) of disease[2] made mandatory familiarity with the conditions

of that legitimation, the status and the actions of those vested with power of legitimation, as well as with their action's institutional setting. He was not endeavouring to set out a theory of professional domination, but to analyse the institutions that support professions, which at that time had received little attention from the sociology of medicine (Freidson 2006). He also made use of the concept of domination in order to discuss the dependency of nurses and assistant care-providers with respect to physicians (Freidson 1970:79-80). The concept of professional dominance extends from that of domination. He deals not only with the profession's structurally dominant place in the division of labour with paramedics, but also explores control over clients, the social definition of disease and the conditions of professional practice. This concept refers back to a specific form of domination that proves indeed appropriate in addressing the power relationships between professional groups in the hospital setting.

The criticism which Freidson voices in the early 1970s regarding the conditions under which physicians were able to exercise their professional dominance – their authority in passing judgement being subject to no external supervision whatsoever – was premised on the assertion that they have an alienating effect on both the patients and the professionals caring for them. The asymmetry in knowledge and uncertainties affecting both diagnosis and prognosis made it impossible for the parties involved to share knowledge. The nurses and other paramedics were able to share knowledge to a certain extent, but continued to be deprived of an all-encompassing view. These were described as the profession's structural limits and imperfections, and not limits or imperfections of an individual nature. Freidson's conclusions (Freidson 1970) and proposals for reform included significant curbing of physicians' professional autonomy and their structural dominance. They suggested that physicians should be required to report administratively on all action undertaken, that they should be held accountable before their patients, and lastly, that competition should be encouraged between certain professional groups or segments.

In France, it is the hospital physicians that hold the dominant positions in the medical field, and that domination "is a factor preserving the field's autonomy" (Pinell 2009). Using Pierre Bourdieu's theory of fields as his model for analysis, Patrice Pinell has looked at the conditions under which an autonomous medical field emerged (since 1795), with differentiated spaces and distinct institutions.

Shifts in medical dominance

The issue of professional dominance, in its incipient stages, was addressed solely within the lines of division of labour in health systems, rather than in the social realm more broadly speaking, despite the fact that the ties between the two appear self-evident. The profession's standing has changed considerably, however, since Freidson's first research.

Within health systems, the current period is marked by receding professional dominance to the benefit of the managerial system (Dingwall 2006). Hospital administration (whether in the United States, in Great Britain or in France) has been

transformed, turning into a managerial power, through the adoption of "Fordist" methods (Dingwall 2006), at an historical point in time, just as Fordism was going into crisis, stirring criticism and being reshaped all at once. The reforms enacted would not have been able to succeed, however, had segments of the medical profession not participated.[3]

Similarly, in France, it was the objective alliance between hospital directors and a fraction of the modernist medical corps, in particular, biologist physicians, that spawned a radical transformation in the hospital as institution, to promote the role of physicians in hospitals (Schweyer 2006). The 1958 Government Orders, influenced by Director of Paediatrics Robert Debré, gave new life to the public hospital sector, by founding the University Hospital Complexes and full-time hospital service. The effects of this reform were felt most of all from the 1970s on. From 1970 to 19M91, the legislative movement reflected the public authorities' determination to refocus hospitals on their technical capabilities, at the expense of their mission as hospice, while the decision to limit healthcare spending drove them to do away with the day-services rate which at the time connected medical activities with the hospital budget.

Hospitals maintained their dominant position during the modernisation of medicine, a position that has grown stronger since the 1958 reforms (Pinell 2008). The effects of the most recent reforms appear contradictory: on the one hand, the institutions and professional groups in the medical community have mushroomed as the status of both physicians and the relationship between care provider and patient was transformed; yet on the other, the economic rationalisation carried out places pressure on working conditions, which threaten the field's autonomy, yet without impinging on the dominant position of the hospital elite (Pinell 2008).

The emergence of directors as professional group

When the concept of financing by comprehensive endowment was introduced in 1983, directors found themselves in a key position, as budget intercessors, and power shifted over to the support organisation, which turned into a leading body (Holcman 2007). From that point on, directors had hold of the resources, while patient recruitment remained in the hands of the physicians. Hospital directors cited their growing responsibilities as grounds for forming a professional group and consolidating their status. At the end of a process during which they momentarily laid claim to their managerial identity, they remained "public sector folk" with their integration into senior civil service in 2001 (Schweyer 2006).

Professional rationale and bureaucratic rationale

Relations between physicians and managers have undergone significant transformations. Freidson had observed, at the start of his research, the tensions that existed between "the experts" and the administrative authority. Once again following Parsons and his critical analysis of bureaucracy, Freidson had noted how, where hospitals were concerned, the tension was alleviated by separating administrative decision-making from professional decision-making. The collegial organisation

mode specific to expert collectives such as physicians, a remnant of the corporative formations of yesteryear, had trouble co-existing with the mighty administrative agencies. That tension was relieved by resorting to a division of labour, through the presence of different subordinate groups, occupying buffer zones between the two main bodies of professional powers. It gradually become recognised that, by promoting a hospital community and forming an organisational culture with shared patient-related values, an institutional identity could be established for both these powers. Medicine remained in the prime position, both culturally and structurally speaking, in its places of exercise (Dingwall 2006).

Furthermore, as medicine became integrated into the hospital environment, the medical profession stratified, rather than declined (Freidson 2001). The world of medicine was, from that point on, structured around three poles: a scientific elite in charge, most prominently, of developing best practices; a new managing elite, established at the interface between the clinic and management; and the practitioner base engaged solely in clinical activity.

Hospital reforms in France and their implications for the profession

Out of the reforms that have reshaped the hospital system in recent times, two are generally recognised as having a major impact by players: "I think that the most important one is the pricing reform, and the governance reform is completely tied in with the first" (Director General, UHC, province). Hospital financing changed radically with the shift from single-endowment financing to pricing by procedure (T2A), in addition to which hospitals' internal and external governance were profoundly reshaped.

Survey methodology

Using two survey campaigns, resulting in 70 semi-directive interviews with hospital directors in 2006 and 2009, we were able to analyse the social representations, points of resistance and appropriation of the reforms by professionals, in particular as regards T2A implementation (Gheorgiu and Moattay 2013). The responses showed that the current reforms need to be seen within the context of a longer history, so as to pinpoint the emergence of new players such as DIMs (Directors of Medical Information) in connection with the implementation of the Information Systems Medicalisation Programme (PMSI).

Three professions – administrative, medical and health executive – are represented in the sample of the persons surveyed. The members of the professional groups differ in training, career path, position in the hierarchy, culture and professional experience, are diverging on the recent or on-going organisational changes and on the computerisation of their establishments.

In search of a new balance between the administrative power and medical power

The recent hospital reforms were intended so that public establishments would enjoy better steering, by taking down the walls between functions and fostering cooperation between three populations guided by different rationale: administra-

tion, medical and care-provision. They reflect a new way of organising and providing tools for power and the exercise thereof in the public sector, which can appropriately be referred to as the "new governance" (Lascoumes and Le Galès 2004). The creation of new managerial tools was intended to overhaul the management, coordination and supervision power held by the state elite in the "Strategic State" over hospital establishments, in line with the principles of New Public Management (Bezes 2009; Belorgey 2010). Against this backdrop, the hospital directors, a professional corps recently integrated into senior civil service, were consolidated in their role as local entrepreneurs of the hospital public service, which it was their responsibility to restructure, given limited resources (Schweyer 2006).

The "new governance" in hospitals was reflected in the 2005 Mattei Orders, which established an "executive board" and clinical and medical-technical "hubs". The executive board is a joint management body involving administrative staff and physicians, alongside management. The activity hubs, which place the former wards under the responsibility of a physician, the hub director, were designed to form medical-economic units with the adequate critical mass.[4] These changes in governance were intended to place responsibility in the hands of hospital directors through a shared medical-economic culture and steering tools. They were supposed to facilitate adaptation of activities and the organisation made necessary by the shift to T2A.

While the objectives set out by the Mattei reform were clear, the evolution of hospital governance includes many twists and turns, reflecting professional battles from the political standpoint. In 2009, the HPST Act replaced the Executive Boards, which balanced out powers between administrative personnel and physicians with "Governing Boards", thus concentrating decision-making power in the hands of the Directors. The Governing Board is a strategic steering body dedicated to discussion and decision, chaired by the Director of the Establishment. It is consulted on key decisions, adopts the medical master plan and prepares the establishment's master plan. The HPST Act was decried by public opinion as instituting an entrepreneurial management mode and placing all of the power in the hands of the "managers", doing away with any joint management structure between the administrative powers and the physicians. The establishment director has the leeway to make decisions in his establishment as would a full-fledged corporate chief executive, all the while reporting to the Regional Health Agencies (ARS), coordinated by a National Steering Board (CNP). Thus, the time of shared powers gave way to a time of vertical integration for the sector, with a clear hierarchical line established and dependency on central political powers. However, this period of hierarchisation of powers is still shifting, and the aim the public authorities now is to provide the hospitals with "democratic and balanced governance", and fully restore the Establishment-Wide Medical Commissions (CME) to their previous level of power, since Marisol Touraine has been in power as Minister of Health.

Working together in the management bodies

Reflecting both the political environment and the struggles between professional groups, the implementation reform process proved very cumbersome on the ground. The new governance experienced different fates, depending on which of its two main sections were involved: the composition of its membership bodies, or the organisation of the hubs.

The changing faces of the management bodies, with the shift from the executive boards to the governing boards, shows the tensions between the administrative and medical powers, and between joint functioning and one in which the director is given a greater role. The current governing boards, chaired by the Director, are in charge of providing support and advice as to how the establishment should be managed and led. The Vice-Chairman is a physician, and Chairman of the CME. As to the members appointed by the Director, the majority must come from the medical corps, while the presence of heads of divisions intended to link up the divisions' strategy with that of the establishment. Last but not least, the Chairman of the Commission on Nursing Care is represented as a member by right of law, which was not the case in the Executive Boards.

The Governing Board is intended as a means of re-connecting the powers between themselves and the cooperation between the administrative and the medical, around a medical-economic rationale, whereas the two professional groups' rationale were separated up to that point. The reform of the management-level bodies it not but an array of power plays, and instead ushers in a new negotiated order (Strauss, 1992). The nature of the powers is changing in that the administrative and the medical find themselves required to work together on the establishment's medical-administrative steering, both from the standpoint of internal contractualisation (division contracts) and for contractualisation with the governing authorities (establishment contract): "Doctors are definitely given greater responsibilities in Management, but they are also given a real impact on the hospital as a whole... I think it is a different power". (Managing Director, UHC, Paris).

The division-based organisation

The division-based organisation implies that the teams work together to develop a shared medical project, the division project, which connects the objectives up with the resources, and which is concluded between the division Head, on the one side, and the Director and Chairman of the CME, on the other:

> We were used to thinking in terms of wards: there was the ward head, who had prerogatives, sometimes well-served and other times not quite so well. Now, though, we are going to turn into a bigger structure, and no one knows yet whether the division Coordinator will be someone with power, or a service type of person, and then we don't have enough perspective to make any overall conclusions, but what I am wondering about is whether the divisions will be buttressed by a full-fledged medical master plan" (CME Chairman, Hospital Centre, province).

Responsibility for the divisions is given to a coordinating physician, a care-provision supervisor and an administrative supervisor, who work in dialogue with management. The physicians in charge of the divisions, assisted by a Division Board, must be empowered:

> They are appointed by Executive Management and the President of the CME, and the Executive Board, subject to the agreement of the Rector, but they are appointed. All of the hospitals have arranged, for most of those applying to become division Head, sessions with a judging panel, where they are required to submit a preliminary master plan for the division, stating all of the reasons for which they feel the division will offer added benefit to the patients and to the institution. That is more or less it - to sum up, a medical master plan, a resource pooling plan, I can show you, and each division head is required to put forth a preliminary master plan. Then there is a meeting with the applicants, and at the Executive Board meeting, we decided whether they will be appointed or not. The pleasant surprise has been that the applicants are generally pretty big names, and generally very motivated people, when we were initially worried that no one would be interested (Task Group Director, UHC, province).

In direct contrast to this are the division coordinator positions, which can be an inlet to a position in power, or be held by physicians with less-established prestige, "second fiddle", as one physician chairing his establishment's CME summed up.

The places and identities of players are redefined with the integration and involvement of the medical corps, and more specifically, the new players formed by division directors, in governance:

> You can see that a number of performance- and quality-related factors are becoming the focus of discussion for division management, when this was not necessarily the case before, under the single-endowment system that existed a few years ago... You can see the professionals stepping in with their technical approach to management, based on economic data, and in my view, it's shaping up to be something interesting, so I think that integration will come of this." (Managing Director, UHC, Paris).

The new players going by the name of division directors do belong to the medical world, but here, find themselves serving as interface between the medical and the managerial.

The formation of medical and medical-technical divisions, aimed at securing a balance between the medical specialities, remains a work in progress. To balance out powers between administrative personnel and physicians is to do more than merely address the skirmishes that can take place in the divisions themselves, and also includes working on the more lateral aspect of delegating powers to the divisions. The said delegation of power diminishes the role of the functional divisions,

which have to refocus on transversal aspects, hence the resistance they have sparked in some groups, such that they remain relatively limited to the initial intentions set out for them. The formation of medical and medical-technical divisions is, moreover, a lengthy and complex process, due to the multiple criteria used to determine groupings: some divisions are structured around organs or systemic pathologies, while others are geographical inn nature, etc. The existence of a common mindset and team spirit between wards and their directors is conducive to their being grouped and working effectively together, as is the construction of new buildings, which makes it possible to materialise them.

T2A or the procedure coding challenge

The implementation of T2A made procedural coding by physicians, with the participation of other categories of personnel, a central component of hospital management. Under this system, revenue is directly dependent on the activities conducted and the quality with which they were recorded through procedural coding.[5] The procedures carried out by the physician, which were already subject to a recording procedure under the PMSI[6] have been made the focus of interest for several wards concurrently, with descriptions and successive interventions that turn them into a collective production, while the forms of surveillance and supervision have been multiplied. These come into play at several different levels, opening practitioners up to suspicion (of deceitful reporting), possible sanctions (for having stated "too much" or "too little" when reporting on procedures), and mandatory substantiation, or in some cases, even injunctions to cut their patients' hospital stay short.

Changes have come about in professional practices and coding, whether centralised, decentralised or intermediate, as well as in cooperative relations in the workplace, in all of the operational teams in the hospital, from the management level to the care provision teams. The interconnection between medical and care-provision activities and recognition for those activities through computer coding for management purposes entails repositioning professional groups between medical information directors (DIM) and computer engineers, between DIMs and financial departments, between DIMs and physicians, etc. The aim here is to reconfigure their identities and areas of intervention, for instance, "the IT Department must align with the needs of its users and the DIM, not the opposite...". It was "very difficult to build acceptance" for the new role-sharing and clear delineation of boundaries, "but it ultimately came through" (DIM-CH).

When coding is centralised, the conflicts between the DIMs and their physician counterparts no longer pertain to the coding itself, but to the information needed to complete it. The discharge summary statements, operation reports, and information entered into the paramedical records then become instruments that help "optimise - without misrepresentation or botched procedures" activities (DIM, Hospital Centre, province). Although physicians do understand the importance of the issue at stake, the DIM's pedagogical role remains a challenge.

The process of formalising medical practice into medical-economic units, as exemplified in coding, has proved difficult to implement due to the diverging rationale driving the players involved: efforts to shorten hospital stays have been condemned as risk-taking in the name of profitability for the hospital-enterprise. For this reason, DIMs stand at the borderline between the administrative and the medical powers, and it is difficult to find applicants to fill this position. Several of those interviewed concurrently serve as DIM and CME President, which fosters their legitimacy with physicians and makes it possible to shorten the information tracking process, though in exchange giving up close relations with clinics and direct contact with physicians. When candidates have long been physicians themselves, they are able to mitigate this drawback and better hear what practitioners have to say.[7]

The DIMs have trouble positioning themselves with respect to their management: they are sometimes caught in the cross-fire between physicians and management, as the coding required for T2A uncovers the battling that continues between organisational standards and professional standards (Boussard 2005). To wit, some managers have instrumentalised the DIMs:

> I have DIM colleagues who have not been CME Presidents, and who raise problems which I never experience, making it difficult for me to take a stance with respect to Management. The DIMs are sometimes torn between the physicians and Management, so much so that some managers have all but absorbed them into their own structures." (DIM and CME President, Hospital Centre, Paris Region).

Segmentation of professional groups

The creation of divisions, and more generally speaking the new governance, has contributed to distinguishing various "professional segments" within the medical profession (Bucher and Strauss, 1961), with differentiated activities and identities. New professional segments, such as the DIM or division heads, are emerging around a function dedicated to interconnecting the professional, administrative and medical worlds. The resulting managerial elite, originating from the medical world, occupies a transitional place between Management and physicians in implementing T2A and the new governance. By diversifying the sources of legitimacy, the emergence of these players contributes to stratifying the medical profession more prominently, between a scientific elite, a new management elite and plain practitioners (Freidson 2001).

The profession is cleaved, with one segment willing to become engaged in a medical-economical management role, complete with an overhauled professional identity more integrated into the organisation and its constraints, and another more traditional segment that wishes to sustain itself solely on the profession's identity. This cleft cannot be reduced to only the stances represented, as groups can continue to assert a traditional identity, including in professions connected with revamping the organisation, as evidenced by the example of one DIM physician who is

also CME President in his establishment, and who expresses reluctance at becoming involved in management tasks which he considers foreign to him: "By creating divisions, the reform requires us to get involved in managing personnel and equipment, neither of which we have the skills nor the appetite to handle" (DIM, CME President, Hospital Centre, Paris Region).

Conclusion: Professions at grips with management

From the professions' standpoint, the relative decline in autonomy enjoyed by clinician physicians does not denote the decline of a profession which moreover boasts increasing numbers. It is a growth in segmentation in the medical profession, itself the result of internal shifts in the profession and developments resulting from reforms to the institution itself. New professional segments such as DIMs or division heads are central to the "profession's institutional integration" (Benamouzig and Pierru 2011) in that they serve as interface between the medical world and the managerial world, by integrating constraints into professional practice. Whereas the reforms are often interpreted in public debate as a violation of professional autonomy, the rise of "managerialism" and the erosion of the autonomy available to managers, rather than being in opposition, can be interpreted as strengthening the institutional integration of professionals. The slipping dominance of professionals to the benefit of the managerial system has been overestimated, in that it reflects an integration of economic constraints by the profession, in a process operated by the managing segments. These all-encompassing interpretations do not, however, do enough to describe the roles of the various professional players who have to reposition and redefine their identities during the concrete implementation of the reforms (Gheorghiu and Moatty 2013).

Where nurses are concerned, the combination of the new public policies on hospitals and managerial rationale has weakened the power of this professional group. It has put care provision managers on much the same footing as that of managers. The supervisory power they have over access to the profession or over nursing personnel management has been called into question. Senior healthcare managers are numerically in decline, when their numbers were already low. The formation of a specific identity between medical rationale and administrative rationale, as is the case with the DIMs, as well as with nursing managers, has turned out problematic. With the creation of management-based rationale, the nursing supervisors in effect craft the reform's implementation within their teams, when they generally are not in favour of them (Divay, Gadéa 2008). By becoming the vehicles to executive management, they find themselves in a conflicting role: it is difficult to substantiate the pressure and working conditions to which the teams are subject, such that their legitimacy from the teams' perspective is challenged.

In conclusion, in the medical sector, the struggle between the "economic power" and the "intellectual power" is reflected in a segmentation of the medical profession, with new hierarchies in which the practitioners find themselves, more than any other group, in dominated positions, facing off against the professional or managing elite. While the profession is maintaining its dominance, it has done

so at the expense of greater intra-professional domination, referred to in terms of loss of autonomy, "proletarianisation", and even fragmentation in the profession.

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Notes

1 The reforms in the hospital institution, of which there have been many these past few years, have undergone contradictory developments. The pricing convergence between the public and private sectors, adopted in 2005, was discarded. When the reference to "hospital public service", initially found in the 2009 Act on Hospitals, Patients, Health and Territories was struck, many critical voices emerged. The new 2012 government and the 2015 Touraine Act, in the process of being adopted, reinstituted hospital public service, overhauling its definition at the same time. Discussants and critical voices faulted the reforms both as being market-focused and facilitating the hospital-enterprise, and as aiming to nationalise healthcare, through the stranglehold it gives the Regional Health Agencies on hospitals.

2 Following in the footsteps of Parsons' analyses (Parsons 1951), Freidson deems disease to be legitimate deviance insofar as it is unmotivated deviance.

3 In particular, the *evidence-based medicine* (EBM) movement, which placed such importance on scientific proof.

4 An appraisal report drawn up by IGAS raised the question of "appropriate mass" or "critical mass" for a hub, meaning "sufficient so that responsibilities or resources can be delegated meaningfully or so that medical projects can be developed", as well as to enable personnel "to develop a sense of belonging to a hub" (Zeggar, Vallet 2010:14).

5 The interviews reflected primarily two ways of coding medical procedures, "centralised" and "decentralised". In the first instance, the Medical Information Director (DIM), in some cases with the assistance of the Medical Information Assistant (TIM), who codes from a standard output report (RSS) provided by the physicians. "Decentralised" coding is done in principle by the authors of the medical procedures, in some cases with the assistance of the nurses, and sometimes subject to verification (by the clinic directors, division heads).

6 The PMSI (Information System Medicalisation Programme), was introduced in France in 1982, by Jean de Kervasdoué, who was then in charge of the Directorate for Hospitals. Inspired by an equivalent American programme, Diagnosis Related Groups (DRG). It records the primary diagnoses and related diagnoses, then codes them using a regularly-revised classification system. The PMSI is the tool that made it possible, twenty years down the line, to institute the T2A in 2000.

[7] Within the population of DIM physicians, a relative majority is made up of public health physicians, without any clinical experience.

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