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Managing clinical integration: a comparative case study in a merged university hospital

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Abstract

Purpose – This paper seeks to explore critical factors that may obstruct or advance integration efforts initiated by the clinical management following a hospital merger. The aim is to increase the understanding of why clinical integration succeeds or fails.

Design/methodology/approach – The authors compare two cases of clinical integration efforts following the Karolinska University Hospital merger in Sweden. Each case represents two merged clinical departments of the same specialty from each hospital site. In total, 53 interviews were conducted with individuals representing various staff categories and documents were collected to check data consistency.

Findings – The study identifies three critical factors that seem to be instrumental for the process and outcome of integration efforts and these are clinical management's interpretation of the mandate; design of the management constellation; and approach to integration. Obstructive factors are: a sole focus on the formal assignment from the top; individual leadership; and the use of a classic, planned, top-down management approach. Supportive factors are: paying attention to multiple stakeholders; shared leadership; and the use of an emergent, bottom-up management approach within planned boundaries. These findings are basically consistent with the literature's prescriptions for managing professional organisations.

Practical implications – Managers need to understand that public healthcare organisations are based on competing institutional logics that need to be handled in a balanced way if clinical integration is to be achieved – especially the tension between managerialism and professionalism.

Originality/value – By focusing on the merger consequences for clinical units, this paper addresses an important gap in the healthcare merger literature.

Keywords Hospitals, Acquisitions and mergers, Integration, Change management, Public sector organizations, Sweden, Health services

Paper type Research paper

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Introduction

Beginning in the 1980s, mergers become one of the most popular restructuring strategies in healthcare as a response to increased market and financial pressures

(Dranove and Lindrooth, 2003; Goddard and Ferguson, 1997). Most research on hospital mergers originates in the US although researchers in the UK have contributed notably with empirical studies (Fulop *et al.*, 2002, 2005). A review of the healthcare literature shows that hospitals typically justify mergers by promising dramatic operational and financial improvements (Bazzoli *et al.*, 2004; Blackstone and Fuhr, 2003; Ferguson and Goddard, 1997). Swedish research shows that an additional justification is claimed for university hospital mergers – a stronger clinical entity post-merger will strengthen the academic mission by providing, for example, a critical mass of patients for education and research (Brorström, 2004; Choi and Brommels, 2009; Hallin, 2000).

Mergers, however, often involve difficult organisational change processes in which multiple factors may lead to failure more frequently than success (Cartwright and Schoenberg, 2006; Kavanagh and Ashkanasy, 2006). It is therefore not surprising that research consistently shows that most mergers fail to achieve their intended outcomes (Cartwright and Schoenberg, 2006). The high failure rate is even more evident in healthcare mergers (Andreopoulos, 1997; Blackstone and Fuhr, 2003; Mallon, 2003; McClenahan, 1999; Todd, 1999). For example, a study of 300 of the 750 hospital mergers that occurred between 1994 and 1998 in the US showed that most failed (Todd, 1999). A general finding is that major operational or clinical changes were not implemented even years after the hospital merger was formalised (Bazzoli *et al.*, 2004; Goddard and Ferguson, 1997). The literature largely attributes merger failures in healthcare to deeply embedded clinical structures of professional culture (Kitchener, 2002) and to multiple dominant coalitions of stakeholders (Denis *et al.*, 1996, 1999), which make rapid, large-scale changes difficult to effect in public healthcare (McNulty and Ferlie, 2002, 2004). Although a sceptical tone has begun to appear with recurring warnings about the folly of "merger mania" (Andreopoulos, 1997; Ferguson and Goddard, 1997; Mallon, 2003; McClenahan, 1999; Todd, 1999), there are no signs of a decrease in merger activity.

The merger trend reached Swedish healthcare in the 1990s, culminating in the high profile merger of the two university hospitals, Karolinska Hospital (KH) and the Huddinge University Hospital (HUH), in 2004. The new entity was called the Karolinska University Hospital (KUH). In 2010, yet another merger between two university hospitals in the south of Sweden was announced. Despite the central role of hospital mergers in the restructuring of Swedish healthcare, few Swedish researchers have studied this area.

Since clinical departments are the organising structures for medical care in hospitals, the consequences for such units are of central importance in the analysis of university hospital mergers (Corwin *et al.*, 2003). Yet most of the research focuses on the hospital as the analytical unit (Cohen and Jennings, 2005; Kastor, 2001, 2003), seldom assessing how clinical operations are affected by mergers. Denis *et al.* (1999) in their study of two university hospital mergers briefly report "paralysis in clinical areas" for both. Moreover, research shows that it is important to examine how middle management deals with complex change processes (Bamford and Forrester, 2003) if we are to understand, *de facto,* what factors advance or obstruct managerial actions following mergers. Yet, we have not found a healthcare merger study that looks specifically at the role of middle management in post-merger processes.

Consequently, guided by previous research, this paper explores critical factors that may advance or obstruct clinical integration after a hospital merger has been formalised. More specifically, we focus on the interplay between the efforts to achieve operational integration initiated by the new clinical managers and the evolving change process. In this way, we hope to shed light on an area that is rarely addressed in the post-merger literature. By comparing two cases (each case represents two combined clinical departments of the same specialty from each hospital site) with different outcomes, this paper seeks to increase our understanding of why clinical integration succeeds or fails following a hospital merger.

Methodology

Context

At the time of their merger in 2004, together KH and HUH had 125 clinical departments. The new hospital management decided that after the formal merger, duplicating departments (i.e. departments from the two hospitals with the same clinical specialty) should be combined into 74 new departments. The formal assignment from the hospital management to all department managers (hereafter referred to as clinical management or clinical managers) was identical: to reduce costs by 10 per cent and to reorganise pairs of clinical departments into single clinical departments, each with a common department management. These goals were to be achieved by the end of 2005.

As background for the study, some definition of terms is necessary: "clinical department" is the organisation, typically within one or several related medical specialties, that provides direct patient care. "Clinical integration" in this study is considered achieved when:

(1) the previously-mentioned formal assignment has been achieved i.e. the cost savings and the common department management;

(2) the clinical staff from the two departments co-operate and consider themselves part of the same new department (i.e. horizontal integration); and

(3) the post-merger clinical operations run smoothly.

Case selection

In order to secure a high degree of data variability and thus limiting the need for a multitude of cases, we looked for examples of clinical integration with different approaches and different outcomes by talking to key informants at KUH and in examining relevant hospital documents. Ultimately this investigative process led us to select the case of Department X (consisting of original Departments Xk and Xh) and the case of Department Y (consisting of original Departments Yk and Yh). The prefix "X" represents a surgical specialty and the prefix "Y" a medical specialty. The suffix "k" indicates that the department pre-merger was at KH and the suffix "h" that the department pre-merger was at HUH. Departments X and Y belong to the same Division Z at KUH. The managers of those two departments were charged with the same task of integrating their units post-merger within the same organisational context.

Data collection

Following the case-study recommendation to combine multiple sources (Eisenhardt, 1989; Leonard-Barton, 1990; Yin, 1994), we conducted interviews with individuals from

the clinical departments and collected numerous public and non-public documents. The data were collected from the years 2004 to 2006. This time frame coincided with the three-year period the regional government gave the KUH management to fulfil their formal merger assignment. We also complemented with some data for 2010, which gave us indications of the status of integration six years post-merger.

For each case, we interviewed 11 people representing various clinical staff categories (i.e. physicians, nurses, secretaries and managers). For both Department X and Department Y, we balanced the number of interviewees from HUH and KH evenly (an exception was the external clinical manager recruited to Department X). In sum, we interviewed 22 members of the clinical staff. To construct the background context to our study, we also interviewed new hospital management members (18 people), the president of the affiliated medical university (Karolinska Institutet), and key informants from the Stockholm County Council (SCC), which is the political decision-making body for public hospitals (12 people). In total, we interviewed 53 people. Using digital audiotape, the same interviewer (the main author) recorded the interviews, each of which lasted from one to two hours. Subsequently these interviews were transcribed. The interviewer used open-ended questions to guide interviewees to present their views on the merger process and the extent of clinical integration, encouraging them to "tell their stories" and asking follow-up questions when necessary.

Data analysis

The main purpose of the interviews was to obtain the clinical managers' and the clinical staffs' views on how the change process evolved during the three years immediately following the merger. To reconstruct the two cases, we structured and analysed our empirical data by iteratively reading the transcribed interviews and then mapping and coding them into main themes and subcategories using a software for qualitative research (NVivo). Data consistency was then crosschecked with other empirical sources to assure high levels of internal validity (Miles and Huberman, 1994). The validation process also involved discussions of the study's themes among ourselves as we challenged and questioned each other in working towards agreement (Patton, 1999; Yin, 1999). Having reconstructed both cases, we defined the distinct feature of both cases according to each theme and category, displayed them in a table (presented as Table I), compared their patterns and sought empirical and theoretical explanations for their different outcomes.

Case descriptions

Context

KUH was formed on 1 January 2004 by the merger of KH and HUH, two hospitals that are 30 km apart, one north of Stockholm (KH), the other south (HUH). Both KH and HUH were publicly funded and governed by the regional government (SCC). Both were university hospitals, which meant that they engaged in research and education in addition to providing clinical care. Both were closely affiliated with the same medical university, Karolinska Institutet (KI).

Research shows that the pre-merger process lasted nearly a decade and took place in both the academic and the political arenas (Choi and Brommels, 2009). In the academic arena, the merger was seen as a way to strengthen KI's international research position.

Table I.
Comparative analysis of clinical integration efforts

	Case X = Xk + Xh	Case Y = Yk + Yh
Σ Clinical integration achieved	No	Yes
Overarching change context	Division Z within the Karolinska University Hospital merger	Division Z within the Karolinska University Hospital merger
New manager's change assignment		
Formal mandate from	Top management	Top management
Economic goal	Cost savings (10 per cent)	Cost savings (10 per cent)
Administrative goal	One common management	One common management
1) Interpretation of the mandate		
Main obligation to:	Top management	1) Senior physicians 2) Top management
Action mode	Directives	Consultation
Change intent	Radical and rapid	Incremental and slow
2) Design of the management constellation		
Recruitment	External	Internal
Initial constellation	One department manager	Two operational managers + one strategic leader
3) Approach to integration		
Decision-making mode	Top-down command	Bottom-up consultation
Organising mode	Coercive control	Voluntary participation
Communication strategy	Direct intervention One-way communication	Divided strategies Two-way communication
Core message to clinical staff	Unfiltered Enforcing cost efficiency	Filtered Enhancing research excellence
Post-merger outcome at year 3		
Formal assignment:		
Cost savings achieved	No	Yes
One common management	No	Yes
Clinical outcome:		
Smooth clinical operations	No	Yes
Knowledge sharing	No	Yes
Organisational outcome:		
Reported staff turnover	High	Low
Organisational structure	Two separate units One additional level	One unified department One fewer level
Management constellation	Three operational managers with overlapping functions	One operational manager + one strategic leader
Horizontal integration	No	Yes

In the political arena, the SCC promoted the merger on the expectation of large and rapid cost savings that would contribute to balancing the county budget by the next election in year 2006. Key stakeholders in these arenas eventually realised that the merger could result in both greater research excellence and increased economic efficiency. However, given the historic rivalry between the two merging hospitals, there was a good deal of controversy and concern about their merger into one hospital. When the formal merger decision was made on 9 December 2003, one of Europe's largest hospital mergers was set to begin (for more details, see Choi and Brommels, 2009).

The interviewed staff members thought the decision-making process was too hasty and did not know why or who had made the "unthinkable" merger decision. They felt frustrated that the decision was made in secret, "over the professionals' heads". Hence, they ignored the merger decision and continued working as usual in the beginning.

The SCC appointed HUH's director as the new hospital director at KUH. As she had had a career in private industry, she shared the SCC chief executive's goal of running the hospital as a "corporation". Thus the executive work (i.e. the actions of the hospital management team) was soon infused with the values of the corporate world. The new director immediately decided to halve the number of managers at all levels and to recruit new managers internally following the hiring principle of "balance and fairness" between KH and HUH, i.e. all pre-merger managers at all levels were given an equal chance in the recruitment for the new managerial positions. Less than a month after the merger was officially announced, the new executive management group on the top level was in place (18 members).

In April 2004, this group, led by its corporate-minded director, started to implement their planned changes. The formal assignment by the executive management to the clinical managers was identical – to reduce costs by 10 per cent with whatever means that would take and to integrate the original pre-merger departments at each site into single departments, each with a new common clinician led management. This assignment was given to the pre-merger clinical managers at KH and HUH who were directed to jointly work out new plans before the beginning of summer 2004. The task for the executive management group, as described previously, was to recruit clinical managers for the newly formed departments. Their goal was to have a new department structure with new clinical mangers in place by the autumn of 2004. (For more details, see Choi *et al.*, 2011).

Department X: the post-merger process

The original clinical departments Xk and Xh (that formed Department X) were approximately equal in size with similar clinical profiles pre-merger. For example, each clinical department provided half elective care and half emergency care. In the last 20 years Xk had had only two clinical managers, while Xh had a history of several clinical managers during those years. Moreover, Xk had a national reputation as a well-run organisation with a strong, cohesive culture under the leadership of a reportedly very popular clinical manager (hereafter "Manager Xk"). Xh, by contrast, was reputed to have a "fractured" leadership and culture. Pre-merger, the two departments sporadically collaborated in research, but they differed in how they organised the clinical work. At Xk, clinical work was organised in an integrated manner; at Xh, activities were divided into three specialised sections. The physicians at Xh also said

they had a "inferiority complex" towards Xk because of Xk's longer history and greater proximity to the medical university (KI).

The KUH hospital management was aware of the significant differences in leadership history between Xk and Xh. Therefore, an exception was made to the "balance and fairness" recruiting principle when Manager Xk was offered the position of Department X manager. This decision was supported by the staff at both sites, including Xh who approved the appointment of Manager Xk as their new leader. However, the harmony was short-lived. Manager Xk's trust in the KUH management soon deteriorated because he thought the new KUH director expressed "too much of a tough business management culture [...] which does not really fit the realities of a hospital". Manager Xk was also concerned with the pressure from the top to reduce staff and, thus, to have to dismiss close colleagues and friends. Soon after his appointment, he resigned from the new position. The staff members at Xk were disappointed when they learned that Manager Xk had resigned. However, since Manager Xk retained his academic appointment at Department X, he continued to receive copies of e-mails and occasionally participated informally in meetings and social events.

When Manager Xk resigned, the KUH management contacted several other physicians as there were no obvious candidates for the position. Those, however, viewed a manager position negatively. Therefore, the KUH management, making an exception to its principle of internal recruitment, opened the search to external candidates. After a lengthy search process, a senior specialist and former clinical manager of another university hospital was hired (hereafter Manager X). Most importantly, he had the scientific credentials demanded by KI. Manager X was enthusiastic about his new job at the "highly prestigious" KUH and had ambitious goals for Department X.

Before officially starting as manager for Department X, Manager X met with KUH's top management to learn their vision for the merger and their expectations of him. He then began planning for an extensive and rapid integration of Xk and Xh consistent with top management's thinking. For example, he planned to immediately reduce costs by combining the clinical specialties of Xk and Xh, thus avoiding duplication of services.

Eager to realise his vision, Manager X started right away to implement planned changes. Although he asked both Xk and Xh staff members to suggest a new structure for the officially merged Department X, he overrode their proposal with his own, more ambitious plan. This move upset in particular physicians at Xk, which increased their already initial suspicions of Manager X. From then on, many Xk physicians did not attend further collaboration meetings for the merger. A senior physician at Xk commented:

> Five meetings were planned. After two meetings, when he [Manager X] decided that we hadn't given him what he wanted, he suddenly put forward his own plan, stating: 'This is the way we will do it'. He had obviously decided on his own plan that had nothing to do with all our work. That was the first nail in the coffin.

The staff members at Xh were less bothered by Manager X and more frustrated by increased top-down control in the whole organisation. Some interviewees felt they were "tied hands and feet". A nurse at Xh said:

> I have become tremendously more frustrated. I can sense that feeling also among my colleagues. This feeling has escalated. I don't just have one boss. I now have many bosses to report to. Before [the merger] I went to one manager and that was it. Now I have to go to the HR managers, division managers, clinical managers, assistants, and so on. I have about five bosses now [referring to the administrative functions centralised to the hospital level].

The staff members from both Xh and Xk thought that a clinical manager must have the support of the medical staff and especially the so-called "senior key opinion leaders", since they set the example for the younger physicians. Manager X however, found it unacceptable that senior physicians were inclined to "drag their feet". Manager X stated:

> There must be some sort of chain of command. Over the years I have been immensely frustrated by the physicians' reluctance to be included in a system like that [. . .]. They don't give a damn about what the County Council decides and announces.

Even as the Xk staff members' resistance to Manager X's change efforts increased, he continued with his change programme as planned using "cost efficiency and economies of scale" as merger arguments. Yet the interviewees said that neither the physicians nor the nurses understood his reasoning and that Manager X was a poor communicator. An Xk physician described this difficulty:

> You need to have a filtering layer in between. You can't just talk that language [financial] with clinical staff. They aren't in these jobs to hear that. They are here for the sake of the patients.

While Manager X struggled to impose integration efforts, the SCC decided to close a ward at Xk, which meant that high volume care and emergency care would be reduced at Xk. The SCC justified their political decision with the argument that rare and complicated patient cases should instead be moved to and concentrated at Xk. Manager X described the fierce reaction at Xk to this decision:

> There was a complete explosion [. . .] hospital management was on my side on this and initially we struggled a lot. At a clinical meeting with the Xk physicians, just before Christmas 2004, when we planned to close the ward, it was almost as if rotten tomatoes were being thrown at us.

The decision to close the Xk ward occurred about the same time as the 2004 Tsunami disaster in Thailand. The Xk ward "made a huge effort" to provide aid to the survivors, hence demonstrating its usefulness, according to the interviewees. Now Manager X made efforts to make KUH management change the political closure decision. Despite his efforts, the Xk staff members saw him as the obedient lackey of the hospital management. However, Manager X was unsuccessful. There was a storm of e-mails. Manager X summarised the situation:

> The general complaint was that the county council, the hospital management, the clinic management and the division management were all run by idiots. Xk, a good clinic with its economy under control, will be destroyed. Everything they have worked so long for is all gone.

The ward was eventually closed and hostilities increased at Xk. Manager X was ultimately called to a meeting by senior physicians and head nurses at Xk who openly

rejected him as their boss because, unlike their former boss, Manager X could not defend the interests of the staff members and the clinic. According to Manager X:

> They told me that they did not trust me, and they did not want me as manager. It was straight out, no frills. I told them that I would listen to them, but it is my duty to make decisions and to implement them.

Once the Xk ward was closed, key Xk staff members left. According to the interviewees, Xk "collapsed". They said "complete chaos" resulted due to inadequate staffing. Nevertheless, Manager X stubbornly continued with his planned change agenda, now assisted by outside management consultants. Eventually, Xk staff members went to the head of Division Z, a KUH management member, and demanded his resignation. The head of Division Z, who had so far supported Manager X in his change efforts, was now under strong peer pressure from Xk to make Manager X resign. Finally, the Division head concluded there was no alternative: Manager X had to resign. A senior physician at Xk described the turmoil:

> It is very difficult to integrate anything against people's will. If you cannot motivate someone, it does not work. You live in another world when you sit in an office. Integration must be on a voluntary basis. We have to have someone who represents the clinic's interests. Our first new clinical manager [Manager X] failed in that respect so we forced him to quit his job. The clinical manager's role is to create trust so that he is perceived as the representative of the clinic. If he doesn't do that, it's only a matter of time until he has to go.

The decision was a shock to Manager X, who told the Division head that he "did not want to disappear – I thought that this could be something". Immediately afterwards, he went to the other hospital site and told the staff members at Xh what had happened. Xh staff members became furious at this turn of events and expressed their antagonism clearly in particular towards the head of Division Z, but also towards the Xk staff members. The Xk staff members however, continued to regard the Xh staff members as their peers and colleagues in their continuous battle against management and the merger.

Three years post-merger, Department X had not achieved the intended cost savings. Nor was the integration of the clinical departments under common management achieved. In fact, the integration process had serious problems from the very beginning that quickly escalated as we could see. For example, the ward closure at Xk caused an exodus of key staff members. "Precious" time was wasted on unnecessary meetings, seminars and commuting between the two sites, all at the expense of the quality and time of patient care according to the interviewed staff members.

After Manager X's resignation, a new manager who had few academic credentials was hired. According to several interviewees, that was seen as a lack of necessary qualifications. Hence a senior physician at Xk assumed the operational leadership for one unit (Xk) and another senior physician at Xh assumed the leadership for the other unit (Xh). These new positions were termed "physician managers" on paper, since there could only be one formal clinical manager. This also meant that an additional management level had been added to the departmental structure – a development that was contrary to top management's goal of reducing administration. The rapid turnover of managers and three new managers with overlapping functions after Manager X's resignation provided enough evidence to staff members that the clinical integration and the merger had failed. According to the interviewees, Xh and Xk had practically no

exchanges or contacts with each other, before, during or after the merger of the two hospitals. Perhaps most significantly, the antagonism of the staff members towards the hospital management and the political leadership had reportedly increased. Three years post-merger, physicians and nurses from both Xk and Xh perceived the distance between the clinical units as "the perimeter of the earth minus 30 km" and that the integration of Xk and Xh had failed. Six years post-merger, staff members still report that Xk and Xh have not integrated in practice.

Department Y: the post-merger process

The original departments Yk and Yh (that formed Department Y) were quite similar in size and structure. For example, they had about the same number of inpatient beds and provided a comparable level of outpatient care. Moreover, staff members at both sites liked their clinical manager. The only significant difference between Yk and Yh related to their research and patient activities. Yk was very research intensive and had a large lab near the medical university (KI), whereas Yh focused more on patient care. At Yk, research was fully integrated with the clinical work, which was even considered its core activity. A professor at Yk (hereafter Professor Yk) was credited with achieving Yk's respected position in the scientific community. While Yh's financial situation was said to be the stronger of the two, Yk was still perceived as the "richer" department, thanks to Professor Yk's research grants. Yk was nevertheless described as a disorganised, risk-taking and academically-oriented culture compared to Yh that was described as more disciplined and organised. Although Yk and Yh had collaborated on several research projects pre-merger, staff members at Yh felt they were "the poor cousin from the country".

Under KUH's "balance and fairness" principle of management appointment, both the Yk and Yh managers applied for the management position at the new Department Y. Staff members at both Yk and Yh responded positively when the Yh manager (hereafter Manager Y) was appointed to the position, although they said they were indifferent as to which manager was selected, since they thought both were competent. Manager Y appointed manager Yk as his deputy manager (hereafter the Deputy). In effect, the two former managers would initially share leadership of the consolidated Department Y. In addition, Professor Yk participated in the team as informal leader. For example, he was involved in all major departmental decisions, especially those related to the long-term strategic issues and research activities.

The operational leadership "in tandem" by Manager Y and the Deputy was evident when physicians from both hospitals worked in mixed groups. Fearing a possible turf battle between the Yk and Yh physicians, Manager Y and the Deputy attended all staff meetings together presenting a united front to both sites. The interviewees thought Manager Y and the Deputy's positive attitude toward the merger was a significant factor contributing to the willingness of staff members to cooperate with each other. One nurse at Yh described Manager Y and the Deputy as follows:

> They set a positive tone. They showed that we could work together and they initiated and facilitated contacts between the two sites. That tone spread to the other managers. They tried very early on to have joint planning days, and so.

Manager Y and the Deputy made it clear from the very beginning that they represented the clinical staff and wanted to promote high quality patient care in the first place.

Moreover, they viewed senior physicians as important and informal "leader" and therefore consulted them on a regular basis. As a result, the clinical staff had trust and confidence in the new management team and in the merger.

Manager Y said that he and the Deputy felt energised by the merger. "It felt good", he said. They planned to make a few changes, as incrementally as possible, using "business as usual" as their guiding principle. For example, to reduce the negative impact of staff reductions on staff morale, no outright downsizing was carried out. Voluntary departures and retirements were not replaced, though. Moreover, to minimise the tension between Yk and Yh, Manager Y alternated the collaboration meetings between the two hospital sites. Manager Y said:

> I have an office at Yh and one at Yk. I also have half a secretary at Yh and a half at Yk. They are two different people. I try to spend my time 50-50 at each place. Commuting between the sites is stressful, but it works pretty well.

Manager Y was aware that staff members wanted and needed autonomy. Therefore he delegated some decision-making authority and maintained an open dialogue with the clinical staff. He thought it was important to acquire informal approval of decisions and changes from all staff members right down to the grass roots level. Staff members appreciated this management style. A nurse at Yh said of Manager Y:

> I think he listens. He makes you feel that you are an important part of the chain. He knows what knowledge you have and the area you are working in. If there is something to do or a coordinator to meet with, he delegates tasks and trusts that the work will get done. So he rarely issues orders.

One telling example relates to Manager Y's response to the formal assignment delegated by top management, i.e. to develop a new departmental structure and to propose suggestions for how to reduce planned expenditures in the next year. Although Manager Y and the Deputy had their own ideas, they asked mixed groups of clinical staff for their proposal. The staff members proposed an incremental change approach including a unified management structure. The agreed proposal was then presented and also informally approved by key R&D representatives in Department Y. In this way, all staff members felt they were involved and valued, and thus became motivated to implement "their" plan.

Another example shows how Manager Y and the Deputy worked to create harmonious collaboration between the Yk and Yh staff members. Soon after the merger, Manager Y and the Deputy created integrated tasks for all staff categories based on medical expertise (subject-specific projects). While participation was voluntary, most staff members participated. They generously shared knowledge and resources with each other and even began to initiate collaborative projects with each other. One Yh nurse described these projects:

> We had subject-specific working groups that you could join, based on your personal interests, such as a particular diagnosis, a special nursing problem, and so on. These groups were mixed from both sites. The situation then was not so artificial... It became a natural way to work with each other because the group shared a common interest. I think it is the interest in the [clinical] work that motivates many of us.

As the formal manager of Department Y, Manager Y reported performance measures and cost savings "upwards" to the hospital management on a regular basis. Although

he communicated feedback to the staff from the KUH management (e.g. that Department Y is "the most successfully integrated department"), he consistently shared the operational tasks with the Deputy when dealing "downwards" with the staff.

Furthermore, Professor Yk (the informal leader of Department Y) supported Manager Y and the Deputy through his strategic role as the visionary of the merger and the key champion for the integration of staff tasks and cultures of both sites. Professor Yk consistently emphasised that the different profiles of Yk and Yh were complementary strengths for Department Y. Furthermore, he gave the Yh staff access to Yk's research resources, such as labs, funding, supervisors and fellow researchers. To the Yk staff, he told them that the research base had increased thanks to a larger patient base and more people from Yh that could engage in research activities as the result of the merger. Professor Yk encouraged the integration of all staff categories across hospital borders as a way to achieve research excellence. For example, in joint research seminars open to all staff members at the affiliated medical university, he made sure to connect the nurses' daily patient care to the ongoing departmental research. By also placing the clinical everyday work in an international scientific context, the staff reported an increased willingness to collaborate and integrate with each other, which even resulted in spontaneous integration initiatives. Most interviewees thought that the title of "Professor" conveyed greater status than that of "Manager".

Department Y achieved both formal merger objectives in the time specified by the assignment – the 10 per cent cost savings and an integrated department with a common management within a year. Staff and manager turnover was low, and group cohesion was reportedly strong. Cooperation between Yk and Yh was essentially problem-free as the two groups supported each another and shared resources in a mutually beneficial arrangement. Yk improved its organisational structure and Yh became more research-oriented. The interviewees agreed that Department Y had improved, especially in research. One year post-merger (2005), Department Y was chosen the "Centre of Excellence" in Europe within its specialty, which furthered a sense of a successful integration. Although still operating on two sites 30 km apart staff shared resources, discussed and used the same clinical protocols and increased their research collaboration (in stark contrast to Department X).

Department Y's management team of two operational leaders -and a strategic research leader was a fortuitous combination. The three leaders were part of the initial constellation that worked harmoniously. Eventually, as the integration process moved forward smoothly, the Deputy returned to his job as a clinician, but the other two leaders remained. Although clinical work continued at both sites, Department Y's management team had successfully integrated Yk and Yh. The staff members felt they belonged to the same department under one common management. More significantly, they shared the same vision – to make Department Y a top clinical practice and a leader in international research. Six years post-merger, Manager Y and Professor Yk still led Department Y.

Comparative analysis

As our two cases demonstrate, clinical integration was achieved in Department Y whereas it failed in Department X although both clinical managers were given the

same formal assignment within the same change context – clinical integration in the aftermath of a university hospital merger. In comparing the two cases, three main themes emerge: the new clinical managers':

- interpretation of the mandate;
- design of the management constellation; and
- approach to integration.

We next develop these three themes as they appeared at the two departments.

1. Interpretation of the mandate

We identified two different interpretations of the formal mandate. In the same change context, top management framed the formal assignment in a similar way for the two newly recruited managers. Since Manager X felt his main responsibility was to the hospital top management, he complied with their top-down directives that included a strong emphasis on reducing costs. As a result, he tried to integrate the clinical departments in a radical and rapid way. Despite the similar pressure placed on Manager Y to conform to top management directives, Manager Y, however, chose a freer interpretation of the formal assignment than Manager X. From the very beginning, Manager Y viewed his obligation as two-fold – he was responsible to the senior physicians as well as to top management. This, among other things, meant that he consulted the senior physicians and worked toward a slow and gradual integration in line with the wishes of the clinical staff.

2. Design of the management constellation

The management constellation at Department X consisted of one externally recruited actor, while the management constellation at Department Y consisted of three internally recruited actors. Manager X made an effort to assume full strategic and operational leadership. In contrast, Manager Y installed the former manager of Yk as his Deputy. In leading the change process in tandem, the two operational managers presented a united front towards the clinical staff at Department Y. In addition, a highly respected professor at Department Y acted as the strategic leader and the visionary champion of the merger towards the clinical staff. As the tension between the two sites faded at Department Y, the Deputy eventually left the management team to return to his role as a clinician. However, the other two leaders remained as the clinical management of Department Y.

3. Approach to integration

Another major difference between Department X and Department Y concerned the two change approaches taken by the managers. Manager X took a top-down planned approach in which he exercised coercive control and practiced direct intervention. He also used an unfiltered, one-way management style to communicate between top management and staff members. For example, Manager X sought to justify the integration among the clinical staff by promoting top management's merger rationale of immediate "cost savings and economies of scale". In contrast, Manager Y took a bottom-up emergent approach with the clinical staff. He asked for the voluntary participation of staff members in the integration activities and respected their need for occupational autonomy. Moreover, Manager Y reported financial and other

performance measures to the top management in the administrative arena, while Professor Yk motivated and communicated with the clinical staff in the professional arena. By taking the informal role as strategic leader, Professor Yk repeatedly emphasised research excellence as the main merger rationale, which evidently encouraged the staff members to engage in prolific clinical integration. Table I summarizes our empirical findings.

Discussion and conclusions

Typically, post-merger integration represent a case of very difficult change processes (Kavanagh and Ashkanasy, 2006). This seems to be particularly true in the healthcare area where research shows that most mergers fail (see Andreopoulos, 1997; Blackstone and Fuhr, 2003; Mallon, 2003, McClenahan, 1999; Todd, 1999). In one example where a university hospital merger was seen as fairly successful at the hospital level (defined as achieving "equilibrium" between the three hospitals involved and creating an inspiring shared vision), very little change was *de facto* achieved at the clinical level (Denis *et al.*, 1999). Thus it comes as no surprise that clinical integration was not achieved for Department X. Previous research points out that it usually takes several years, even a decade, before synergies are materialised in knowledge-intensive contexts (Birkinshaw *et al.*, 2000). Goddard and Ferguson (1997) also conclude that clinical changes typically are not fully implemented even years after a hospital merger has been formalised. Thus Department Y's successful integration achieved within a year is somewhat of an anomaly. How can we better understand these remarkably different outcomes? Although several factors might have advanced or impaired the integration process, we found three main factors that seem to have been instrumental for the different outcomes in our two cases – the clinical managers':

(1) interpretation of the mandate;

(2) design of the management constellation; and

(3) approach to integration.

Next we discuss these empirical findings in relation to previous research.

Interpretation of the mandate: one vs two masters

The KUH top management was given a clear formal mission from the regional government to save costs through the merger of two university hospitals (KH and HUH), which in turn shaped the formal directives given to all new clinical managers:

- to save costs (10 per cent); and
- to combine pairs of duplicate clinical specialties into single departments with common department managements.

This logic resembles the classic ethos of top-down control and co-ordination (Denison, 1997), which through the advancement of marketisation, the New Public Management (NPM) reforms and mergers (Kitchener and Gask, 2003) has strengthened vertical lines of organising in public healthcare (McNulty and Ferlie, 2002, 2004). Possibly as a result of having been brought in from the outside by the hospital management, Manager X saw top management as his "master" and readily accepted the cost-reduction assignment as his main mission. This became the basis for his initial actions and his

mimic adoption of top management's planned top-down approach. Moreover, he considered himself primarily "manager", which resembles the "bureaucratisation" thesis of physician managers (Kitchener, 2002). This is like the minority group of physician managers at a New Zealand university hospital who sought a new identity as managers while adapting to their new commercial environment (Doolin, 2002). This also mirrors the challenges of such a "hybrid position" (Montgomery, 2001, Kitchener, 2002), that we observed among physician managers at the executive level (Choi *et al.*, 2011). When Manager X eventually tried to shift his loyalty from management to the medical professionals, it occurred when their trust in him was already severely damaged at one site, which eroded necessary capacity-for-action needed to shift to a bottom-up change strategy (Haspeslagh and Jemison, 1991).

In contrast, Manager Y was a long-standing colleague of the senior physicians and recognised early on the necessity to seriously consider multiple competing logics, by also paying attention to the professional logic. Although he believed he had both the top management and senior physicians as his "masters", he felt a greater commitment to the physicians. This is in line with Montgomery's (2001) research on physician managers, and places him in the majority of physician managers as characterised by Doolin (2002). In other words, he re-interpreted the formal assignment in a way that he thought accorded better with the context where the change took place. Manager Y's nerve to re-interpret formal directions reminds us of the importance of recognising the complex link between plans, processes and outcomes of managerial change initiatives (Burnes, 2004b; Pettigrew, 1997).

Our data indicate here that in a situation where a manager already enjoys a great amount of trust, the space for a freer interpretation of the mandate seems to be larger, which in turn may facilitate the management of the change process itself (Holmberg, 1986). In fact, healthcare literature shows that trust from professionals is a central component necessary for clinical managers to be effective as leaders, especially under conditions of uncertainty such as in mergers (Montgomery, 2001). This is also in line with the post-merger literature, which points out that the establishment of trust among professionals is perhaps the most necessary factor to achieve integration of professional service organisations (Empson, 2001a, b).

Design of management constellation: individual vs shared leadership

Although merger studies have pointed out that post-merger integration processes can differ somewhat, the challenge of overcoming "horizontal" cultural differences between the merging organisations has still remained in a central position (Datta, 1991; Fulop *et al.*, 2002; Ramaswamy, 1997, Sales and Mirvis, 1985). Our data show that the initial and temporary installation in Department Y of two operational managers in tandem helped to handle the potential danger of horizontal conflict between the merging departments. In addition, the research leader's effort to promote the merger as a way to advance research excellence further reduced the "horizontal" tension inherent in mergers. Notably, his research vision generated a strong sense of unity in a shared "professional arena" common to all clinical staff categories from both sites (Empson, 2001a, b). That positive vision most probably contributed to a "readiness for change" (Armenakis *et al.*, 2001) among Department Y staff members. By confirming their belief that their high standing in research could be preserved and

improved, their sense of psychological safety, control and identity was strengthened (Weiner *et al.*, 2008).

Another well-documented tension typical in healthcare organisations arises from the potential conflict between managers and professionals (Degeling *et al.*, 2003). In particular, the sociology literature on professions has examined this tension (Evetts, 1999; Freidson, 1984). In our study, two actors effectively handled the "vertical" tension: an informal strategic leader (Professor Yk) who took the responsibility to encourage integration among professionals and a formal operational manager (Manager Y) who took the responsibility to report performance data to top management. In fact, shared leadership became an effective way to meet both top management's requirement of timely reporting on cost savings and the clinical staff's demand for research excellence. This division of responsibilities between the professional and administrative domains resembles the decoupling strategies often found in highly politicised settings, such as public health care (Brunsson, 2002; Meyer and Rowan, 1977). It also demonstrates a separation of the challenging hybrid function for clinical managers to balance dual and often conflicting need and demands of both the organisation and the medical profession (Montgomery, 2001).

The general change management literature typically attributes the acceptance of change and the achievement of functional outcomes to the skills and abilities of "strong individual leadership" (Hammer and Champy, 1993). The leadership role taken by Manager X, however, demonstrated the difficulty in exercising strong leadership in an organisational context that requires paying attention to both the managerial and professional arenas (Montgomery, 2001). As seen in Department Y, shared leadership seems to be better able to cope with the often conflicting logics and goals of multiple stakeholders inbuilt in public healthcare, especially the tension between the competing institutional logics of managerialism and professionalism. Thus our study shows that an overemphasised reliance on "strong individual leadership" as a basis for managing complex change could not be assumed (McNulty and Ferlie, 2002). The useful division of the clinical management function might actually call for a shared leadership where each actor has the main responsibility for one "pure" arena (professional or administrative) rather than one actor being responsible for balancing two arenas, which resembles the management constellation used by other highly professionalised groups such as journalists, lawyers and artists.

The literature also provides us with other plausible explanations of the successful clinical integration of Department Y. The two formal and one informal leader acted as an "integration team" (Haspeslagh and Jemison, 1991), that had high legitimacy because of its very composition of leaders, who were accepted both managerially, professionally and scientifically (Balogun and Hailey, 2008). The team also constituted a management constellation which was effective because each had a distinct role and yet collaborated smoothly (Denis *et al.*, 2001). We could observe that formal roles were "downplayed" rather than emphasised, and that informality characterised their relations. That kind of distributed leadership is known to be effective especially in organisations where power is diffuse and interests are multiple (Chreim *et al.*, 2010). In the university hospital merger reported by Denis *et al.* (1999), multiple leader roles and collaboration among leaders were assessed as important factors behind the equilibrium achieved among sites.

Approach to integration: planned vs emergent approach

Merger researchers have noted that the change approach selected by managers may have considerable effect on the process and outcome (Kavanagh and Ashkanasy, 2006). For example, a recent merger study of large, multi-site public sector organisations concludes that an incremental approach is preferred because it produces more satisfactory outcomes for individuals (Kavanagh and Ashkanasy, 2006). This resonates well with the approach that was taken in Department Y.

Drawing on more generic parallels, the top-down approach adopted by Manager X clearly resembles the classic planned approach to change, which is assumed to be more suitable in stable or predictable environments (Bamford and Forrester, 2003; Burnes, 2004a). In contrast, the bottom-up approach adopted by Manager Y resembles the emergent approach, which is anticipated to be more appropriate for unpredictable and uncertain conditions (Bamford and Forrester, 2003; Burnes, 2004b). Given the high degree of contextual complexity in our study (e.g. the current hyperturbulence of public healthcare, advanced professional services, the merger situation and key actors holding strong professional identities), the emergent approach proved without doubt, more successful.

A specific study on two university hospital mergers introduced the same dichotomy although differently phrased. A "constraining contract" or "protocol" approach launched at the hospital level was less successful than an "inspiring vision" produced in consultation with stakeholders on different levels (Denis *et al.*, 1999).

The finding that the incremental and the emergent approaches were successful agrees with previous merger research on professional organisations. For example, merger research notes that professionals typically control the pace of integration at all levels (Empson, 2000). It is evident in both our cases that the medical professionals took an important role early in the change process, which also is traditionally the norm in healthcare (Kitchener, 2002), since medical professionals exercise considerable power and autonomy (McNulty and Ferlie, 2002, 2004). In fact, research shows that change efforts imposed in a classic top-down manner may cause professionals with valuable knowledge and skills to leave an organisation, thus eroding potential merger synergies (Empson, 2001a, b). This could also be clearly seen at Department X. At Department Y however, the research leader created supportive conditions for a smooth integration by emphasising "research excellence" as the primary motivating factor behind the hospital merger. As mentioned, he involved all staff categories from both sites in a context broader than mere clinical practice, which resembles literature's strong recommendation of practicing sense-making to facilitate integration of professional organisations (Empson, 2000, 2004).

Although these findings seem to broadly support an emergent approach to integration, a closer look at Department Y reveals that the emergent change took place within planned boundaries set by the management, which reflects a more recent research stream that combines planned and emergent change (Bamford and Forrester, 2003; Bartunek, 2003; Beer and Nohria, 2000a, b; Burnes, 2004a).

Concluding remarks

Although previous research clearly points out difficulties in avoiding negative effects when merging hospitals (Fulop *et al.*, 2002, 2005), our study shows that merger pitfalls to a certain extent may be avoided when thoughtful, inclusive management practices

are employed. So, what are the implications for clinical managers? In sum, our study shows that the following managerial practices seem to be instrumental for the outcome of clinical integration efforts:

(1) Managerial practice impairing integration (Department X):
   - an unfiltered interpretation of the formal mandate with one master;
   - a management constellation based on individual leadership; and
   - the use of a classic, planned top-down approach.

(2) Managerial practice facilitating integration (Department Y):
   - re-interpretation of the formal mandate to include multiple masters;
   - re-design of the management constellation based on shared leadership; and
   - the use of an emergent, bottom-up approach within planned boundaries.

To achieve successful clinical integration, it seems important for new managers to dare to make their own interpretations of formal mandates, to dare designing a new management constellation based on shared leadership including informal leaders rather than a "pure" individual formal leadership, and to have the courage to open up for a dialogue with the professionals during the process. Trust-building seems here to be a critical factor. Managers need to pay more attention to the fact that public healthcare organisations are based on multiple institutional logics that need to be handled in a balanced way. In particular, our study shows that the "vertical" tension between managerialism and professionalism seems to be a bigger challenge for managers than the "horizontal" difference between the merging organisations as predicted by the general merger literature. In theoretical terms, our study implies that clinical integration is promoted by a management constellation that addresses both managerial and professional concerns and pays equal attention to all key stakeholders, both externally and internally. Success is enhanced by a vision creating sense for the proposed organisational arrangements and increasing readiness for change. If decision-making and communication strategies are tailored according to key stakeholders, this distributed leadership will reach across hierarchical levels.

Finally, we want to draw the reader's attention to the limitations of the study. Although a multiple case study might be seen as a well-argued approach to study the complex phenomenon of clinical integration post-merger, its dependence on stakeholder interviews inevitably introduces subjectivity, some of which might have been addressed by performing direct observations. That was not done out of resource constraints, which is a weakness of the study. The relatively short time-frame of the study is another weakness. It should be noted, though, that contacts with a subset of interviewees six years post-merger confirmed that the reported differences between the two departments (integrated vs. non-integrated) had persisted unchanged. As to the generalisation of our findings we addressed the challenge of external validity by comparing and testing our results with a wider body of literature. While our findings are basically consistent with the general prescriptions for successful change management of professional service organisations, care must be taken when transferring the findings and tentative explanations from this particular study to other contexts.

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