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Competing Logics in Hospital Mergers

The case of the Karolinska University Hospital

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The picture on the cover is painted by Byung-Eun Choi, 1995 (in memory of my father).
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This book is dedicated to

my father and my mother

Change is disturbing when it is done to us, exhilarating when it is done by us…

R. M. Kanter

ABSTRACT

Introduction. Today there is no doubt that mergers have permeated all sectors of society, including health care. Starting in the US, extensive waves of hospital mergers occurred at a record pace in the 1980's typically justified by promising dramatic financial and operational improvements. In the 1990's, the merger trend reached Europe and by the turn of the century "merger mania" had taken a strong hold within the UK. By the end of the 1990s, there had been a number of hospital mergers in Sweden. In 2004, Karolinska University Hospital was formed through the flagship merger between the Karolinska Hospital and the Huddinge University Hospital. In 2010, yet another prestigious merger of two university hospitals was announced with the formation of Skåne University Hospital. However, there has been almost no research on hospital mergers in Sweden. The aim of this thesis is to increase our understanding of the pitfalls and possibilities in merger processes by exploring the Karolinska University Hospital merger.

The merger in brief. On 1 January 2004, the Karolinska Hospital and the Huddinge University Hospital merged to form the Karolinska University Hospital. Although the merger was controversial and far from obvious, the merger decision passed by a single vote in the Stockholm County Council on 9 December 2003. To achieve a balanced budget by the next political election in 2006, the new director of the merged hospital was told to reduce expenditures by €70 million over the next three years. The top management delegated identical assignments to all clinical managers: to reduce costs and to consolidate 125 clinical departments into 74 new departments each with a common management. Over the three-year period (2004 to 2006), the predicted cost savings for the merger were not achieved. Eventually the original implementation plan was withdrawn and the hospital director left the organization.

Methodology and research questions. An embedded case study design was used to explore pre- and post-merger processes, in which data was collected by interviews, non-participant observation and extensive documents (allowing triangulation). Three studies addressing different organisational levels examined the following issues: how and why a merger decision that was considered "impossible" became possible (Study I); how and why top management's radical ambitions resulted in an unintended convergent process and dysfunctional outcomes (Study II); how and why considerably different outcomes in terms of clinical integration occurred at the clinical department level (Study III).

Results. Spanning from the years 1995 to 2007, the three studies show that the merger processes evolved through a non-linear, undirected and complex interplay between external and internal actors. The process was mainly driven by the competing institutional logics of *managerialism* in a political and administrative arena, and *professionalism* in a scientific and professional arena. Means convergence and a politico-economic crisis led to the merger decision. The top management was overwhelmed by the "vertical clash" between managerialism and professionalism. On the clinical department level, managerial factors that hindered integration were a sole attention on the formal mandate from the top management, leadership based on one formal actor, and the use of a planned top-down approach to change. Managerial factors that facilitated integration were a dual attention to two majors stakeholders (top management and clinical staff), shared leadership between multiple actors, including an informal leader, and the use of an emergent, bottom-up management approach to change within the planned assignment.

Discussion. The key finding is that the competing institutional logics between managerialism and professionalism seems to be the main driver of merger processes. This vertical conflict is probably the main explanation why intended outcomes were not achieved. While top management followed the merger literature's classic recommendation to focus on the horizontal tension and to take a planned linear top-down approach to change, the unanticipated challenge stemming from the competing institutional logics made it difficult for the management to handle the post-merger process. A true understanding of the intra- and inter dynamics inherent in a context with multiple layers of competing institutional logics, such as public sector health care, seems essential to produce functional organizational outcomes.

LIST OF PUBLICATIONS

I. Choi, S., & Brommels, M. (2009). Logics of Pre-merger Decision-making Processes The case of Karolinska University Hospital, *Journal of Health Organization and Management (JHOM) , 23* (2), 240-254.

II. Choi, S., Holmberg, I., Löwstedt, J., & Brommels, M. (2010). Executive Management in Radical Change – The Case of the Karolinska University Hospital merger, *Scandinavian Journal of Management*, DOI:10.1016/j.scaman.2010.08.002.

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CONTENTS

LIST OF ABBREVIATIONS

KUH	Karolinska University Hospital
HUH	Huddinge University Hospital
KH	Karolinska Hospital
KI	Karolinska Institutet
NPM	New Public Management
QRS	Qualitative Research Software
SCC	Stockholm County Council

1 INTRODUCTION

1.1 THE MERGER PHENOMENON

Today there is no doubt that mergers have permeated all sectors of society, both private and public, including the health care sector. The merger phenomenon can be traced all the way back to the US manufacturing industry and its legendary "Great Merger Movement" from 1895 to 1905 (Lamoreaux, 1985). During this period, it is estimated that 1800 firms were consolidated (Ibid.). These consolidations formed the foundation for what was later termed "big business". Industrial mergers ever since have followed a similar wave-like pattern, revealing five waves throughout the 1900s (Barkoulas et al., 2001; Gärtner & Halbheer, 2009). In 2004, 30 000 mergers were completed globally, which is equivalent to one merger every 18 minutes at a total value exceeding the GDP of several large countries (Cartwright & Schoenberg, 2006). Well into the 2000s, mergers have remained a highly popular tool used to create value, renew organizations and/or restructure industries.

In the 1980s, the merger trend hit the health care sector typically justified by promising dramatic financial and operational improvements (Bazzoli et al., 2004; Goddard & Ferguson, 1997). Starting in the US, extensive merger waves occurred at a record pace. While in the 1980s, efforts focused on horizontal alignment, in the 1990s efforts focused on both horizontal and vertical relationships to functionally align service delivery into one integrated system (Ibid.). By the mid-1990s, the hospital merger activity in the US had increased nine times since the start of the decade (Williams et al., 2006). This was soon followed by a merger wave in the UK of their National Health Service trusts (NHS). Between 1997 and 2001, 99 mergers of NHS hospitals took place (Fulop et al., 2002, 2005) and by the turn of the century "merger mania" had taken a strong hold within the UK (Cereste et al., 2003).

In Sweden, restructuring of the health care sector began in the mid-1980s, leading the way for hospital mergers in the 1990s. By the end of the 1990s, the merger trend reached the academic health care community with the formation of the Sahlgrenska University Hospital[i] on the west coast of Sweden (Brorström, 2004; Hallin, 2000). In 2004, Karolinska University Hospital was formed through the flagship merger between the Karolinska Hospital and the Huddinge University Hospital. Both were university hospitals located in Stockholm on the east coast of Sweden. In 2010, yet another prestigious merger of two university hospitals was announced in the south of Sweden with the formation of Skåne University Hospital. Although researchers agree that mergers of university hospitals seem to have become a "non-infrequent" phenomenon (Kastor, 2010), there is almost no research done in this field.

For over 40 years, the complex phenomenon that mergers represent has attracted robust academic interest from multiple disciplines. However, the substantial body of empirical data has largely produced mixed and often contradictory findings. The knowledge of mergers in health care is even more uncertain and scarce due to its shorter history. Because of this inconclusive knowledge and a continuing merger trend, it is clear that more research is needed to further examine mergers, particularly those occurring in health care. This thesis addresses university hospital mergers.

1.2 MOBILIZING MERGERS IN HEALTH CARE

While recognizing that mergers once began in the US manufacturing industry back in 1895, one might wonder how and why this phenomenon entered Swedish health care in the 2000's? Although this question is beyond the scope of this thesis, a quick overview of how and why mergers may have entered the field of public sector hospitals is valuable for the later discussion in this thesis.

Among various perspectives, the notion of *competing institutional logics* between *managerialism* and *professionalism* provides a convincing explanation of the historical background of the mobilization of mergers in the health care sector (Friedland & Alford, 1991). In particular, this notion directs us to the wider social and political transformations in health care. At different time periods, different ways of organizing, financing and managing health care have dominated. As a particular logic dominates health care in each period, that logic has formed the basis for discussions on how health care should function. Scott et al. (2000) divides the US health care into three distinct periods. The first period (1945-1964) was a time of professional dominance; the second period (1965-1982) was a time of state governance and national ownership; and the third period (from the early 1980s and forward) has been dominated by competition, market and management. Although caution should be taken in drawing parallels between different countries, research shows that this historical description of different logics dominating health care in different periods generally applies in many Western cultures including Sweden (Östergren & Sahlin-Andersson, 1998).

The managerial logic of health care, which now dominates health care, is based on two main doctrines (Estes & Alford, 1990: 174): (1) "The resurgent ideology of the market that proclaims that competition and efficiency are the major criteria that justify state expenditures" and (2) "The ideologies of individualism, neo-conservatism, and self-help that justify reductions in or the elimination of state expenditures altogether."

From an institutional perspective, there is a political agenda behind these doctrines that aims to repress the logic of professionalism that had dominated public health care in most Western countries (Brock et al., 1999). From a market-managerial perspective, professionalism distorts the operation of markets, promotes rising costs, and encourages "producer capture" of services. Hence, professionalism has come to be viewed as a serious obstacle to the development of rationalized managerial control (Ackroyd, 1995). Against the background of escalating health costs in the 1980s, the US political reformers proposed two main solutions. First, health care was redefined from a "social good" to an "economic good" (Shortell et al., 1985). Second, there were renewed calls for hospitals to adopt "business-like" structures and managerial practices (Arndt & Bigelow, 2000; Fennel & Alexander, 1987).

The mobilization of these policies involved clear attempts to replace the prevailing professional logic and bases of legitimacy with a countervailing logic of market-managerialism (Kitchener, 2002). In 1981-1982, the logic of market-managerialism was further legitimized with the passing of federal legislation that encouraged competition among providers in US health care (Scott et al., 2000). In 1983, an even more decisive shift towards market-managerialism occurred when US policy moved from retrospective reimbursement of hospital costs to prospective payment linked to diagnosis-related groups, or DRGs (Ruef & Scott, 1998). This shift increased

competition among health care providers and gave further legitimacy to the logic of market-managerialism.

The shift towards market-managerialism in political ideology was especially difficult for US university hospitals (Starr, 1982) because they were required to compete with health care providers who were less burdened with the financial responsibilities of the academic mission (Reuter & Gaskin, 1997). By the mid to late 1990s, such university hospitals also had ceased to be reasonably profitable partners for medical schools. Even elite university hospitals experienced substantial operating losses (Kitchener, 2002). From this institutional perspective, mergers are just one example of the logic of market-managerialism or the New Public Management philosophy (NPM), as it is sometimes evocatively known (Kitchener & Gask, 2003; McNulty & Ferlie, 2002, 2004).

1.3 DEFINITIONS

1.3.1 Definitions of mergers

Mergers can take a variety of forms – and there are many ways to categorize mergers. Typically, researchers differentiate merger types based on the *relationship* between the merging firms *before* the merger. The literature usually divides mergers into four major categories: horizontal, vertical, conglomerate and concentric mergers (Kitching, 1967). In *horizontal* mergers, the merging firms belong to the same industry and are at the same level in the value chain. That is, they serve the same customers and/or use the same suppliers producing similar goods or services. In *vertical* mergers, the companies also belong to the same industry, but have different roles in the value chain (i.e. they are customers or suppliers for each other). In *concentric* mergers, firms either serve the same customers with different products, or offer similar products to different customers. In *conglomerate* mergers, the merging firms offer different products to different customers, usually to reduce financial risks through a diversified portfolio (e.g. with respect to business cycles). To mention another commonly used categorization, horizontal, vertical and concentric mergers belong to *related* mergers, while conglomerate mergers belong to *unrelated* mergers (Amit & Livnat, 1988; Chatterjee, 1986; Napier, 1989). Because we examine a merger between two Swedish university hospitals that offer similar services within the same "industry", the definitions of merger used in this thesis are the *horizontal* and *related* mergers.

In health care a merger occurs when two or more hospitals join operations to create a new hospital entity (American Hospital Association, 2010). Such operational consolidations may not involve a legal transaction if the hospitals are owned by the same parent company. Also, multiple facilities may still exist even after consolidation. Hospitals that simply cease operations experience "closures" (Ibid.). "Acquisitions" – which is more applicable for hospitals in private hands - are defined as the event where one or more hospitals are financially subsumed into an existing hospital entity (Ibid.). In this study, both mergers and acquisitions are referred to as "mergers" (see also Section 2.1.2).

1.3.2 Definition of university hospitals

In the health care literature, it is common to talk about university hospitals, affiliated teaching hospitals and academic health centres (AHCs) as a single phenomenon. In this thesis, the term "university hospital" is used for all types of academic hospitals since it is the term used in Sweden. University hospitals differ from other health care providers by having a distinctive tripartite academic mission: research, education, and clinical care. This implies, among other things, a formal affiliation and a close cooperation with a medical school. Most affiliated medical schools are based on collegial academic structures with a dean overseeing powerful department chairs who usually control large budgets. By contrast, university hospitals tend to have a more hierarchical structure. At their apex, a chief executive oversees departmental Directors and negotiates with medical staff (see e.g. Kitchener, 2002). Although the literature does not make any clear distinctions between university hospitals, it may be good to note that about half of university hospitals in the US are owned by state governments (e.g. UCSF), with the other half in private hands (e.g. Stanford and Harvard) (Kitchener, 2002). In Sweden all university hospitals are public institutions. In essence, all university hospitals are unified by the same logic of clinical and research excellence, which is deemed vital to realize their tripartite mission (Yusuf, 2006).

2 PREVIOUS RESEARCH

2.1 MERGERS IN THE INDUSTRY

2.1.1 Introduction

Previous research on mergers has been dominated by US studies because most mergers have occurred within the corporate segment in the US. Many of these studies can be found among financial economists, who typically have conducted research of listed companies at the macro-level. Bearing in mind that the governance and institutional contexts between privately owned firms and public sector organizations (such as university hospitals) are fundamentally different, it is still important to relate this thesis to previous research although it originates in the private business sector, because they may face many of the same managerial and organizational challenges post-merger. This section outlines the major findings resulting from 40 years of research on mergers in the industry.

2.1.2 Mergers & Acquisitions

In the general management literature, it is common to talk about mergers and acquisitions as a single phenomenon, which is reflected by the abbreviation "M&As". Although research does not always make any clear distinctions between mergers and acquisitions, it may be useful to note one distinguishing aspect from a legal point of view. Typically, mergers are used to describe a "merger of equals" where the firms are often of about the same size, while acquisitions occur when one company takes control of another and clearly establishes itself as the new owner as reflected by the number of shares owned. From a legal point of view, in an acquisition, the buyer "swallows" the target company, which ceases to formally exist (DePamphilis, 2010). Usually one company will buy another and simply allow the acquired firm to proclaim that the action is a "merger of equals" (even if it is technically an acquisition) because being bought out usually carries negative connotations (Ibid.). Because the companies are more unified by the logic of going forward as a single new company, with similar goals and challenges, the literature usually treats M&As as a common phenomenon. Guided by literature prescription, this thesis uses the term "mergers" interchangeably for both mergers and acquisitions. The use of the term "mergers" also highlights the fact that the focus in this thesis is on two similar organizations of equal size that merged into one organization. Of course, the concept of shareholders is inapplicable for public organizations, such as university hospitals.[ii]

2.1.3 Merger motives

Why do mergers occur? In an increasingly competitive global market, mergers have been and continue to be a popular and legitimate way to create rapid growth and to improve competitive advantage compared to, for example, organic growth. In the capital markets mergers are justified by their possibility of quickly creating shareholder value. However, most observers agree that mergers are driven by a complex pattern of motives, and that no single explanation suffices (Ravenschaft & Scherer, 1987; Trautwein, 1990). In merger prescriptions the most popular justification for mergers is the possibility of realizing synergies. Synergy is often expressed as the "2+2=5" effect, or as "the combined performance that is greater than the sum of its parts" (An-

soff, 1965). In essence, synergies are described as having a latent value that can only be realized when companies merge.
The literature typically divides synergies into three types (Chatterjee, 1986; Trautwein, 1990): (1) Financial synergies that chiefly reduce the cost of capital and also diversify industries against various business cycles (i.e. spread of financial risk); (2) Operational synergies that are aimed at increasing operational efficiency through shared functions, for example, in purchasing, production and distribution; and (3) Monopoly-based synergies that are intended to achieve a dominant market position and thereby increase bargaining power.

What does the evidence say? In an ambitious attempt to classify merger motives (into seven categories) according to their plausibility and consistency with the evidence, Trautwein (1990) concludes that explanations based on the popular efficiency theory (i.e. the above noted "financial and operational synergies") and monopoly power (i.e. the above noted "monopoly-based synergies") are less supported by evidence than by other explanations such as managerial empire building. Because merger justifications generally rely on efficiency arguments, he concludes that they are "dangerous guides for participants in merger processes" (Trautwein, 1990: 283).

2.1.4 Merger outcomes

In terms of reaching intended merger goals, research consistently shows that mergers lead to failure more frequently than to success (see e.g. Cartwright & Schoenberg, 2006), by for example reducing the value for the shareholders (King et al., 2004). Already in the 1960's, Kitching (1967) reported a pessimistic merger failure rate of 75 per cent and a less pessimistic failure rate of 46–50 per cent in his later work from 1974. Later studies from the US report equally poor failure rates of 77 per cent (Marks, 1988) although a less pessimistic failure rate of 50 per cent was reported in European studies (Cartwright & Cooper, 1992; Hunt, 1990). Porter (1987) also notes a failure rate of 50 per cent in an often-cited study. Despite these "high" failure rates, mergers are a growing phenomenon, which puzzles and interests many researchers (see review by Cartwright & Schoenberg, 2006).

2.1.5 Suggested explanations

So, why do most mergers fail to achieve their targeted goals? Over the years, several possible explanations have been offered in the literature. While it is not possible to mention all of them, some of the most well-known are noted here. As mentioned (see Section 2.1.3), mergers are not always motivated by value-adding motives but rather by non value-adding motives such as managerial empire building in many cases (Trautwein, 1990). The principal-agency theory is useful in this context since this theory has long recognized that a manager's interests may diverge from those of the firm's owners, because a manager's pay, power and prestige typically are closely related to the size of the company (Berle & Means, 1932). Consequently, a manager, acting in his or her self-interest, may choose to invest company funds in projects that increase the size of the company, even though such an increase may not necessarily be profitable for the investors or the company as a whole (Mueller, 1969).

In particular, poor organizational fit or a lack of cultural compatibility is frequently cited as the main reason for merger failures (e.g. Datta, 1991; Sales & Mirvis, 1984). "Organizational fit" refers to "horizontal" differences or tensions between the administrative and cultural practices of merging firms and can also refer to personal antagonisms (Ibid.). Research shows that how

the management executes its post-merger integration plans including the handling of horizontal differences, likely has an important influence on merger outcomes (e.g. Haspeslagh & Jemison, 1991).

Several researchers recommend managers normative models in order to realize potential synergies (e.g. Kitching, 1967; Larsson & Finkelstein, 1999). For example, a successful "horizontal" integration of top management is proposed as a prerequisite for a subsequent smooth integration process further down the organization (e.g. Kotter, 1996; Santala, 1996). The post-merger work of management has often been described as a balancing act between actions aimed at achieving the merger's formal goals and actions aimed at minimizing the negative influence on the personnel. This dichotomy in managerial work is often referred to as the "business side" and the "human side" (Larsson, 1990) or as "task integration" and "human integration" (Birkinshaw et al., 2000). Several researchers (e.g. Birkinshaw et al., 2000; Haspeslagh & Jemison, 1991) suggest that the most successful integration begins with creating a safe and positive environment for the employees – that is, by addressing "the soft" human side of work *before* addressing "the hard" business side.

2.1.6 The case of professional firms

Researchers agree that large companies (Miller & Cardinal, 1994) and knowledge-intensive organizations (Birkinshaw et al., 2000) are more complex and therefore considerably more difficult to integrate than small companies (Cartwright & Cooper, 1993; Nahavandi & Malakzadeh, 1988). For example, a study of mergers between large pharmaceutical companies shows that it may take 7 to 10 years before potential synergies start to realize (Birkinshaw et al., 2000).

In particular, research shows that different managerial challenges arise in organizations in which the employees provide professional services based on their personal expertise (Greenwood et al., 1994; Løwendahl, 2005). In professional firms, the management must rely on autonomous experts and hence has limited control of the firm's core activity. As a consequence, the employees control the integration tempo to a higher degree than in the traditional industry (Empson, 2000, 2001; Greenwood et al., 1994). In fact, research shows that the integration process *at all organizational levels* is highly dependent on the professionals' trust and willingness to cooperate (see e.g. Empson, 2000, 2001). If the management pressures professionals too hard, research shows that the risk is high that they leave the organization, taking valuable knowledge with them (hence damaging potential merger synergies). Some researchers even recommend that management refrain from taking deliberate planned actions if such actions might harm employees' trust (Graebner, 2004). What matters is that professionals of merging firms must first have confidence in each other, which may take some good time (Empson, 2000, 2001).

Even if the management of professional firms may not steer the integration process, research shows that management still can influence the process by placing the merger in a larger context that creates true meaning for the professionals. In fact, research shows that the use of "the management of meaning" (Smircich & Morgan, 1982) can even encourage professionals to *spontaneously* initiate integration across company boundaries (Graebner, 2004), although it may take several years before such spontaneous cooperation occurs (Empson, 2000, 2001).

2.1.7 General conclusions

Despite a robust body of data from the private business sector, general conclusions are difficult to draw on why some mergers succeed and others do not. However, the capital market school has been able to produce some key *consistent* findings from over 40 years of research. These general findings are summarized here:

Waves in merger activity: Today there is a broad consensus in the scientific community that mergers occur in waves. Since the first report on merger waves (Nelson, 1959), many studies have reported a wave-like pattern in merger activity. Technically, this means that aggregate merger series are characterized by "large" bursts of activity separated by lengthy intervals of very low activity or extreme swings back and forth between low and high levels of merger activity during a certain time period (Gärtner & Halbheer, 2009). In the financial literature, empirical evidence on the time series structure of aggregate merger activity in the US economy has attracted considerable attention, particularly the merger waves in the mid-1980s (Golbe & White, 1988)[iii] and the mid-1990s (Harford, 2005)[iv].

Target firm gains: Early as well as recent research consistently shows that, on average, shareholders of target firms earn significant gains while shareholders of acquiring firms neither gain nor lose (Agrawal & Jaffe, 2000; King et al., 2004). US studies show that shareholders of the target firm gain between 20 and 30 per cent, whereas shareholders of the acquiring firm, gain only between 0 and 4 per cent (Jarrell et al., 1988). Similar findings are reported in other countries (Haspelagh & Jemison, 1991).

High-risk strategy: Over the years, there has been little change in merger failure rates (50-75 per cent). As a result, there is a solid consensus among researchers from various disciplines that most mergers fail to achieve their intended outcomes and therefore is considered as a high-risk strategy (for more details, see reviews by Cartwright & Schoenberg, 2006 and Haspeslagh & Jemison, 1991). The current dominant view among merger researchers is therefore that merger as a way to create corporate value *de facto* is a high-risk strategy that at best lead to short term value creation for target firms, and, at worst, are almost a sure way to lose money.

2.2 MERGERS IN HEALTH CARE

2.2.1 Introduction

Starting in the 1980s, extensive waves of hospital mergers occurred at a record pace, which increased the storms of an already uncertain health care environment. Matching this was a research wave of activity among scientists, industry experts, and consultants studying horizontally and vertically integrated organizations (Burns & Thorpe, 1993; Shortell et al., 1994). As with industrial merger research, most of the health care research comes from the US, where hospital mergers have a longer history. In Europe, the UK has contributed the largest share of research (see the review by Goddard & Ferguson, 1997). Although merger research in health care has existed for a significantly shorter time than in the traditional industry, a sufficient number of studies have been made that reveal a complex puzzle of multi-dimensional pieces of causes and consequences. Yet several efforts have been made to identify patterns of consistency and inconsistency in the health care restructuring literature (see e.g. Bazzoli et al., 2004; Goddard & Ferguson, 1997). Among these, Bazzoli et al.'s (2004) comprehensive review deserves extra attention because it focuses simultaneously on motives, context, process and the outcomes of mergers that coincide with the aspects of special interest to this study.[v] This section presents major findings reported by this review in combination with other key studies of mergers in health care (e.g. Fulop et al., 2002, 2005).

2.2.2 Merger motives

A general assessment of the literature shows that hospitals typically justify mergers by promising dramatic increase in *financial and operational efficiency* (Bazzoli et al., 2004; Goddard & Ferguson, 1997). For example, Bazzoli et al. (2004) find that stated merger motives are: improving organizational efficiency, financial performance, long-term survival, community accountability, and patient outcomes. Fulop et al. (2002, 2005) mention economic gains, reduction of excess capacity to treat patients and increased effectiveness in certain clinical specialties (as the amount of activity increases) as typical merger arguments. Both Bogue et al.'s (1995) study of hospital mergers in the 1980s and Bazzoli et al.'s (2004) study of hospital mergers in the 1990s find that the three primary anticipated merger benefits were: (1) to strengthen financial performance, (2) to consolidate services and (3) to achieve operating efficiencies. Moreover, in the 1990s large hospitals merged with each other rather than with small and weak hospitals to increase market power in order to better fend off managed care and other environmental pressures (Alexander & Morrisey, 1988; Eberhardt, 2001; Lesser & Brewster, 2001). Overall, previous research suggests that hospital mergers primarily are driven by cost efficiency-generating or revenue-enhancing motives.

However, when we look more closely at the literature, we can see some important variations. While anticipated financial efficiency emerge repeatedly as the key driver, studies of public sector hospitals show that *political drivers* may also be key merger motives (Denis et al., 1992; Fulop et al., 2002). Political drivers for mergers may include facilitating hospital closures and ensuring increased negotiating power for health care providers (Fulop et al., 2002). For example, Denis et al., (1992) show in a pre-merger study of two public hospitals in Canada (including one university hospital) that politics was a key determinant of the merger decision. Hence, they conclude that hospital mergers in the public sector do not necessarily result from efficiency

motives. In the UK, Fulop et al., (2002: 1) also point out that mergers of the NHS trusts "have often been contentious politically", resulting in the formation of independent panels to "take out the politics" in merger decisions. Yet they find that important merger motives included *unstated* drivers (e.g. the need to respond to lobbying from political stakeholders) as well as *stated* drivers (e.g. the need to make internal savings) (Ibid.).

2.2.3 Merger outcomes

In terms of outcomes, Lynk (1995) shows that consolidation of hospital departments could result in greater financial predictability and lower peak load staffing due to reductions in the variability of demand. Wicks et al., (1998) conducted case studies of hospital mergers and conclude that operational efficiencies could be generated through consolidating key administrative functions, eliminating service duplication, closure or conversion of underused inpatient capacity, and exploiting economics of scale. Other researchers have focused not only on the potential monetary costs of implementing change, but also on the toll on organizations as they respond to challenges and potential resistance, which show a post-merger decline in efficiency (Dranove et al., 1996; Fulop et al., 2002, 2005; McClenahan, 1999). Taken together, the efficiency outcome after hospital mergers is rather mixed.

The only study Bazzoli et al., (2004) found that looks beyond financial effects of hospital consolidation and integration is a study by Ho and Hamilton (2000) who examine whether quality of care changed when hospitals merged. They find no quality improvements resulting from hospital consolidation and limited evidence of quality deterioration on a few indicators. Fulop et al., (2002, 2005) find that the loss of managerial focus had a negative effect on delivery of health services. There has also been considerable interest in whether improved health care quality outcomes can be gained from concentrating the hospital care through mergers. For example, Williams et al. (2006) find that hospital *concentration* decreased hospital quality while hospital *competition* increased it. Sowden et al. (1997) conclude that there is no good evidence to indicate that increasing volume will result in improvements in quality outcomes when quality is associated with volume,

These findings contrast with a study that took a "patient safety" approach to the integration of two hospitals (Gering et al., 2005). The authors conclude that patient care is not disrupted and that post-integration data show that performance remained constant or improved for the predefined measures of access and quality. Overall previous findings on quality outcomes are mixed. The difficulty of defining and agreeing on quality measures (highly disputed) seem not only to have produced mixed findings, but also to have limited research on quality outcomes after mergers (Bazzoli et al., 2004; Sowden et al., 1997).

2.2.4 Suggested explanations

Previous research suggests that the hospitals are usually able to consolidate and integrate administrative functions, but clinical integration is harder to achieve. One explanation is that roles, responsibilities, and lines of authority are clear in administrative hierarchies, which makes it straightforward to identify duplicative functions and rationalize administration (Bazzoli et al., 2004). Research posits that these facilitating factors are not present in clinical structures, which makes clinical integration much more complex (Ibid.).

Research also points to the obstructive role medical professionals take by altering the pace of integration (Ibid.). Fulop et al., (2002, 2005) largely attribute delays in clinical integration to those in leadership positions who fail to anticipate the disruptive effects on clinical staff. Overall, researchers agree that integration of clinical departments requires time to build trust, to obtain buy-ins, and to deal with resistance from the medical professionals (Bazzoli et al., 2004).

Another explanation for "dysfunctional outcomes" of hospital mergers is offered from an institutional perspective. Within this thought school, researchers assert that the logic of market-managerialism (e.g. NPM) has increasingly gained influence in the public sector through managerial innovations such as mergers (see e.g. Ferlie, 1997; Kitchener & Gask, 2003). Hence, leading institutional scholars largely attribute merger failures to the conflict between market-managerialism and medical professionalism inherent in health care. Deeply embedded professional structures combined with multiple dominant coalitions of stakeholders in governmental sectors (i.e. conflicting agendas of politicians, unions, media, patients) make mergers and other examples of radical change attempts such as BPR (Hammer & Champy, 1993) are not only extremely difficult to effect (McNulty & Ferlie, 2002, 2004), but also ill-suited in public health care (Cooper et al., 2006; Kitchener, 2002).

Even if various explanations have been suggested for the high rate of hospital merger failures, a vast majority of previous research attributes the main obstacle for bringing hospitals together to the *horizontal differences* between the merging organizations (see e.g. Fulop et al., 2002: 5). For example, the tendency for one management team to dominate the other is mentioned as an early "horizontal" tension that may impede intended change at later stages (Cohen & Jennings, 2005; Fulop et al., 2002; Kastor, 2003).

2.2.5 The case of university hospitals

Introduction

Mergers of university hospitals have historically been relatively rare within the health care sector. However, during the 1990s, several leading university hospitals in the US merged (Kastor, 2003, 2010a, b). In Sweden, three high profile university hospital mergers occurred in the first decade of the 2000s. Apart from two reports on the Sahlgrenska University Hospital merger (Brorström, 2004; Hallin, 2000), there is no Swedish research available on university hospital mergers. Because most of the research comes from North America, findings summarized here largely originate from this scarce pool of research.

Merger motives

A review of the research clearly shows that bottom-line economics and not medical or quality concerns drove university hospital mergers in North America (Kastor, 2003, 2010a, b; Mallon, 2003; Pellegrini, 2001). For example, Kastor (2003, 2010a, b) observes that income did not match expenses, and the hope was that hospital income would rise or at least not decline further through mergers. Although the potential to compensate for internal shortcomings inspired many of the merger makers, Kastor (2003) claims that university hospitals consolidated to build up market power. Overall, US mergers seem to have followed an industrial model driven by increasing financial and market pressure just as at non-academic hospitals (Kastor, 2003, 2010a, b; Mallon, 2003; Pellegrini, 2001). In contrast, Swedish studies of a merger including one uni-

versity hospital (the Sahlgrenska University Hospital merger) report that an additional stated merger motive in parallel with increased economic efficiency was to optimize conditions for research and education that would strengthen the academic mission (Brorström, 2004; Hallin, 2000). Kitchener (2002) offers yet an alternative motive. By studying the field of university hospitals including an in-depth case study of the failed merger attempt of UCSF/Stanford (dissolved on 1 April 2000), Kitchener (2002) suggests that as part of the political agenda to repress the prevailing institutional logic of professionalism, executives are expected to uncritically adopt certain managerial innovations, such as mergers, to maintain organizational legitimacy.

Merger outcomes

Kastor has reported on four mergers involving eight university hospitals in the US with different outcomes (Kastor, 2003, 2010a, b). From an economic point of view (i.e. stated motive), he concludes that two mergers are qualified successes ("Partners" in Boston and "New York - Presbyterian Hospital" in New York) and two are failures ("UCSF-Stanford" in California and "Mount Sinai-NYU Health" in New York) that resulted in dissolution of the mergers (i.e. legal separation) (Ibid.). As one interviewee stated: "The merger took two integrated functioning entities and converted them into three dysfunctional entities" (Kastor 2010b: 1831). In addition to these cases, the merger between North Shore Health System and Long Island Jewish Health System is considered "a very strong successful merger" (Cohen & Jennings, 2005: 178), whereas the merger between Penn State University and Geisinger Health System was a failed merger resulting in dissolution two and a half years after the announcement (Mallon, 2003; Pellegrini, 2001). In the case of the Sahlgrenska University Hospital merger in Sweden, loss of cost control and existing economic problems were still reported six years after the formal merger announcement (Brorström, 2004). Research generally shows that rapid consolidation of nonclinical departments (i.e. administrative functions) with single leadership appointments were achieved early on, but that clinical integration stalled (Cohen & Jennings, 2005; Kastor, 2003). In addition, Kastor (2003) also find considerable integration of educational activities in successfully merging hospitals. In sum, the motives and outcomes of university hospital mergers reported in the past are mixed.

Suggested explanations

So, how do these scholars explain outcomes of university hospital mergers, and do these differ from mergers of "ordinary" hospital? Some researchers claim early and escalating financial losses contribute to the dissolution and the failure of mergers (Kastor, 2010b; Mallon, 2003; Pellegrini, 2001). Kitchener (2002: 392), however, agrees with Staw and Epstein (2000) stating that dysfunctional outcomes may arise "when executives jump on bandwagons to adopt certain merger myths uncritically". He argues that against the basis of market-managerialism, powerful change agents (e.g. the popular business press, business leaders, business schools, the management consultant industry) have promoted mergers so successfully that they have achieved mythical attributes (Meyer & Rowan, 1977). This, he argues, explains why the intended outcomes of merger rarely emerge when managerial innovations are "sedimented" (Cooper et al. 1996) uncritically upon the enduring structures of professionalism.

Kastor (2003) also notes that the conflict between economic, medical and academic logics can pose obstacles to successful integration. However, in a more recent study, Kastor (2010b) attributes the main reason for university hospital merger failure (such as Mount Sinai-NYU Health System and UCSF/Stanford) to the "horizontal" tensions, clashes and oppositions existing at different levels of the faculties, medical school, senior leadership and trustees of the

merging organizations. His focus on horizontal differences is in line with a review of over a dozen university hospital mergers where each merger included at least one AHC (Cohen & Jennings, 2005). Cohen and Jennings (2005: 176) even suggest "perhaps the dominant reason for merger failure is cultural incompatibility between the two organizations" (see also Shaw, 2003). Again, the horizontal tension as the main explanation for university hospital merger failures does not differ from those found in the general merger and health care literature.

2.2.6 General conclusions

Overall, the evidence on merger outcomes from hospital mergers seems mixed, patchy and even contradictory. However, Bazzoli et al. (2004) note that although studies of the effects of horizontal hospital mergers seem to yield a mix of findings, a closer look reveals that some key results have been fairly consistent. These more general findings reported from an extensive review of twenty years of hospital restructuring together with short comments on related articles are presented next.

Initial and quick consolidation of administration: Studies by Bazzoli et al. (2002) and case studies by Lesser and Brewster (2001) found successful consolidation of administrative functions (e.g. financial management, human resources, managed care contracting, administrative practices, strategic planning, and quality assurance functions) among horizontally merged hospitals. Consistent with these studies, Eberhardt (2001) and Wicks et al. (1998) found that administrative functions were consolidated by merging hospitals, and that these actions typically occurred quickly.

Obstacles when integrating clinical services: With the consolidation of the administration completed, the hospitals studied by Eberhardt (2001) focused on consolidating patient support functions and low-volume clinical services. This, too, succeeded without much difficulty, but the hospitals stumbled with the next step, namely, wide-scale clinical service consolidation and the closure of one of the merging hospitals. These studies are consistent with Fulop et al.'s (2002, 2005) findings that senior management had underestimated the timescale and effort required for the merger (service developments were delayed by at least 18 months). Although Shortell et al. (1994) have suggested that quick consolidation of administration (i.e. "small wins") may provide the basis for dealing with tougher issues at a later point (i.e. more complex clinical integration), the studies noted above provide little support for this view.

Full mergers lead to cost savings: If one were to look at studies that examine only fully merged hospitals (i.e. legal mergers under one license and owner) and not include those with multi-hospital affiliations, one would observe more consistency in results. Namely, several studies on full mergers per se have achieved positive cost savings (Alexander et al., 1996; Connor et al., 1998; Dranove, 1998; Eberhardt, 2001; Lesser & Brewster, 2001). All studies that have found no costs savings or cost increases examined multi-hospital arrangements (Dranove et al., 1996). Recent research by Dranove and Lindrooth (2003) specifically contrasted cost changes after mergers with cost changes after system affiliation; their results confirm once again that full mergers lead to cost savings, while loose system affiliations do not.

Limited and minimal cost savings: Although it may be tempting to conclude that full asset mergers are essential for achieving at least some cost savings from hospital mergers, the results of these studies indicate that cost savings from full mergers are quite limited. They tend to be

small (Connor et al., 1998; Lesser & Brewster, 2001), may simply represent movements away from prior inefficiency (Alexander et al., 1996), are limited to smaller hospitals and are quickly exhausted (Dranove, 1998), largely result from administrative savings (Eberhardt, 2001), and may simply be one-shot savings rather than reductions in rates of cost growth (for further details, see the review by Bazzoli et al., 2004).

With financial motives, high failure rate and the horizontal tension as the main outcome explanation, we can clearly see that the literature on health care mergers (including the case of university hospitals) does not differ fundamentally from the traditional merger literature. In particular, it largely agrees with the merger literature on professional service firms.

2.3 THEORETICAL PERSPECTIVES ON MERGERS

2.3.1 Introduction

Since the 1960s, the phenomenon of mergers has attracted the research interest from a broad range of disciplines. Within each discipline, significant advances have been made. After more than 40 years of research, the area of "mergers" has therefore been firmly established as a distinct research field (Cartwright & Schoenberg, 2006; Schweiger & Walsh, 1990). In this section, the dominant theoretical perspectives that have emerged are outlined using Haspeslagh and Jemison's (1991) well-cited categories: 1) *the capital markets school, 2) the strategy school), 3) the organizational behaviour school* and *4) the process school*. Although all these schools concentrate on mergers, each school is rooted in a different elementary research questions.

2.3.2 The capital markets school

The capital markets (or financial) school is the oldest school and can be traced back to the early 1960s. Finance scholars have primarily focused on the issue of whether mergers are wealth creating or wealth diminishing events for shareholders. The capital markets school is typically interested in mergers' impact on the financial performance of firms on an aggregate level, measured as shareholder value. The fundamental question is "Do mergers create value, and if so for whom?" (see e.g. Chatterjee, 1986). Researchers in this school perceive value as "shareholder value" and value creation as "economic gains for the shareholders". The methodological approach used is to study share prices of merging firms during periods surrounding the merger announcement. Two continuing research issues within this school are a) how to measure the financial performance of a merger and b) the division between the interests of the target firm and those of the acquiring firm.

2.3.3 The strategic school

In the 1980s, the strategic school developed as a response to the fact that the capital markets school could not explain merger outcomes, specifically the high number of reported "failed mergers" (see Section 2.1.4). Although it has links to the capital markets school, the strategy school is more interested in the effect of mergers on the business performance of individual firms. The strategy school is primarily concerned with i) finding ways of maximizing profit through mergers and ii) avoiding obstacles to this value creation. Researchers in this school are guided by two fundamental questions: a) what types of mergers e.g. related, unrelated (see Section 1.3.1) are more likely to be successful in terms of improving profit and business performance? and b) how can one search for and evaluate mergers that have the proper "strategic fit"[vi] for maximizing profit? Hence, researchers in this school are usually divided into two subgroups: a) the performance group and b) the planner group. The first subgroup tends to focus more on the extent to which a potential target firm is related to a firm's existing business. The second subgroup typically includes academics, consultants and reflective practitioners and is therefore more interested in providing firms with practical advice on effective planning (Kitching, 1967). While little consensus has emerged from this school (King et al., 2004), researchers at least agree that mergers' underperformance cannot be sufficiently accounted for by the "goodness of the strategic fit" alone without taking into account the wider integration process.

2.3.4 The organizational behaviour school

The organizational behaviour school (hereafter, the OB-school) developed as a response to the inability of ”the capital markets school” or “the strategic school” to explain the high rate of merger failure (see Section 2.1.4). This school has often sympathized with employee concerns, and has closely examined employee reactions that lead to resistance to change (Cartwright & Cooper, 1992; Napier, 1989). With its diverse origins in psychology, organizational behaviour and human resource management, researchers in this school have tried to explain merger underperformance in terms of the cumulative dysfunctional impact that the subsequent integration process has on individual members of the organization. Thus this school is often said to deal with the “soft” aspects of mergers (Cartwright & Cooper, 1993). The OB-school can roughly be divided into three groups: 1) human resource management researchers, 2) crisis researchers and 3) culture researchers. The human resource management group focuses on the human problems (anxiety, stress, ambiguity, etc.) that employees involved in the post-merger process experience, and on ways to prevent or minimize these problems, for example, through extensive communication (Schweiger & DeNisi, 1991). The crisis group views mergers as one example of organizational crisis, whereas the culture group is interested in the cultural compatibility between the merging organizations (Buono et al., 1985; Nahavandi & Malekzadeh, 1988). The OB-school typically explains merger failure with poor organizational or culture fit[vii] (in this thesis, referred to as “horizontal”), which has long dominated as one of the main explanations for merger outcome (see Section 2.1.5). The main goals for this school is to find out i) why problems occur in post-merger integration processes and ii) how to avoid such problems in order to meet intended goals from a managerial perspective (profit, shareholder value). This growing field of research has produced rather mixed and often contradictory results to date (Cartwright & Schoenberg, 2006).

2.3.5 The process school

Among the four schools described here, the process school is the newest and the fastest growing thought school. Like the other schools, the process school has developed as a response to previous research’s inability to explain merger outcomes in a satisfactory way. The process school is often described as a blend of the strategic school’s emphasis on economic performance on organizational level (“hard aspects”) and the OB-school’s focus on cultural challenges on individual level (“soft aspects”). The process school is mainly concerned with how the processes affect merger outcomes. Hence, the link between the merger process and the outcome of that process is of main interest (Haspeslagh & Jemison, 1991). Process school researchers are also concerned with the issue of how the management *per se* acts to create value in the integration process. For example, Seth et al. (2002) observe a number of biases in the process, including drawing the wrong analogies, the illusion of control, and the escalation of commitment, by specifically pointing out “managerial hubris” driving executive post-merger work. Research has also shown that the change approach selected by managers may have considerable effect on the outcome. For example, a recent longitudinal study of three large, multi-site public sector organizations shows that an incremental approach is preferred in terms of producing more satisfactory outcomes for individuals (Kavanagh & Ashkanasy, 2006). As in most merger research, the process school has found it difficult to draw general conclusions. A possible reason may be that mergers seem to be highly context sensitive, which implies that care must be taken when generalizing findings from one domain to another (see e.g. Kitchener, 2002; McNulty & Ferlie, 2002; 2004).

2.3.6 Current trends and recent advances

The merger literature continues to be dominated by the capital markets school, with a high concentration of financial studies continuously coming from the US and the UK, although the human or "soft" aspects of mergers have received more attention in recent years (Cartwright, 2005). Within the capital markets and strategic schools, much current research deals with the identification of the antecedents of the variances in returns for "the acquirers" (see Section 2.1.7). As an example, Sudarsanam and Mahate (2006) argue that single hostile bids, despite negative press, deliver higher financial returns than other bidder types (such as friendly or multiple hostile bidders). Within the OB-school, a growing stream of international studies with a focus on cultural differences and cross-cultural clashes at national levels can be noted, which matches the increase in cross-border mergers (Søderberg & Vaara, 2003). Within the process school, a recent study (Teerikangas & Very, 2006) tried to sort out some of the issues on the current inconsistency in the research evidence. These authors suggest that more longitudinal studies are needed. Cartwright and Schoenberg (2006) note, however, that longitudinal studies are rare because it is difficult to maintain representative sample sizes over time, particularly because attrition rates are higher than normal in mergers. Because "a huge portion of variance remains unexplained" (see Cartwright & Schoenberg, 2006: 4) by unspecified variables, existing knowledge is incomplete in some way, which implies changes to both theory and research methods (King et al., 2004: 188). As guidelines for future opportunities, recent independent meta-studies are particularly noteworthy, which conclude that a greater recognition of *process-oriented* studies is needed in future merger research (see e.g. King et al., 2004). Leading scholars in the health care management literature, also assert that future research on hospital mergers should look at aspects that link the process of change to the outcomes of change if new insights are to be made (Bazzoli et al., 2004; McNulty & Ferlie, 2002, 2004).

3 RATIONALE OF THE THESIS

3.1 POSITIONING THE THESIS

In a direct response to the current call for more process-oriented studies, this thesis is positioned within the newest and fastest growing dominant thought school: the process school. In fact, leading scholars from various disciplines have identified the merger process as a core issue because of its indisputable influence on merger outcomes. (Haspeslagh & Jemison, 1991; Porter, 1987; Shrivastava, 1986). Above all, process researchers point out that there are impediments embedded in the actual merger process that obscure its complexity and thereby makes it difficult for managers to take a holistic view of challenges in advance (see e.g. Jemison & Sitkin, 1986). In other words, leading scholars of the process school (e.g. Greenwood et al., 1994; Jemison & Sitkin, 1986; McNulty & Ferlie, 2002) criticize and question other schools' assumption that management has the ability to anticipate and handle relevant strategic and organizational differences (see Section 2.3.3). In essence, the process school takes the critical and complex *link between process and outcome* as its point of departure (see also Section 2.3.5). Within the health care restructuring literature, very few merger studies have examined the link between process and outcome (Bazzoli et al., 2004). To complement current merger literature, this thesis devotes considerable attention to the pre- and post-merger processes in order to identify and better understand the critical factors that may affect the process development and outcome of hospital mergers.

3.2 GENERAL AIM

Although the process school is the latest significant theoretical school to produce a substantial amount of research, there is still little knowledge on the merger processes in large and complex organizations, especially in professionalized, public service settings such as health care. Furthermore, the literature emphasizes that integration is an organizational issue that must be dealt with at all organizational levels if the full effect is to be realized (Shrivastava, 1986). Still, studies of hospital mergers that deal with all the organizational levels are rare. This thesis fills identified knowledge gap by addressing and linking *all organizational levels* i.e. from the political decision level, executive management and clinical management levels to the clinical staff level. In addition, unlike most other merger studies, this thesis explores both *pre- and post-merger processes*. Therefore, the general aim of this thesis is as follows:

To explore a merger of two university hospitals, and thereby to add to the limited stock of empirical research on merger processes in public sector health care. The theoretical aim is to increase the understanding of the pitfalls and possibilities in merger processes at large and complex organizations, especially in professionalized, public service settings.

3.3 SPECIFIC OBJECTIVES

3.3.1 Rationale of Study I

Several researchers have recognized the *pre-merger process* as a potentially important determinant of merger outcomes (Denis et al., 1992; Haspeslagh & Jemison, 1991; Jemison & Sitkin, 1986; Trautwein, 1990). For example, research shows that inappropriate decision-making and negotiation in the early phases of merger processes can lead to inferior merger outcomes (Ibid.). Furthermore, Haspeslagh and Jemison (1991) report that management's efforts to justify mergers in the pre-merger process tend to produce a simplified picture of merger motives. This in turn can lead to problems when conditions change in the post-merger integration process, for example, with the introduction of new key players. However, a stronger research interest in the consequences of mergers than in their antecedents has meant that relatively little attention has been paid to pre-merger processes and merger motives even though motives may explain why mergers occur (Trautwein, 1990). Research shows that the classic merger motive based on the efficiency theory is insufficient as an explanation of the integration process and its outcome. Therefore it is recommended that merger research should be redirected toward explanations that build on decision-making processes and conflicting goals in the pre-merger process (Denis et al., 1992; Trautwein, 1990).

The relationship between the *pre-merger process* and the *post-merger process* is, given its importance, understudied. Most researchers in the process school focus on the post-merger integration process. This focus leaves the pre-merger decision-making process in a scientific "blind spot", which is even more evident in health care. In order to fill this knowledge gap, the first study places the pre-merger decision-making process at the centre. The objective of this study is as follows:

To examine how and why a decision to merge two university hospitals might occur in a public sector context.

3.3.2 Rationale of Study II

An imperative finding within the process school is the importance of top management for the outcome and success of the post-merger process (see e.g. Finkelstein, 1999; Kitching, 1967; Larsson, 1990). Larsson (1990) further argues that management's post-merger work is empirically distinguishable from other organizational phenomena. For example, research shows that successful integration of an entire organization requires first a successful horizontal integration of the top management group (Santala, 1996). Other researchers suggest that "managerial hubris"[viii] (Seth et al., 2002) may contribute to failed mergers. Such hubris may prohibit a holistic view of the organization and a realistic identification of relevant differences (Ibid.). Taken together, process researchers agree that it is extremely important to study top management's actions and handling of the post-merger integration process as a way to better understand critical factors that may facilitate or obstruct intended success of mergers.

Despite the fundamental role top management plays in the development and outcome of post-merger processes, few merger studies look specifically at the role and work of the top management group (Schriber, 2008). This research gap is even more evident in public sector health care. In order to fill this gap, the second study places top management's post-merger work at the centre. The objective of this study is as follows:

To examine top management's work in implementing mergers defined as radical change initiatives.

3.3.3 Rationale of Study III

An important observation of the process school is the importance of the operational management (i.e. the clinical management in the health care context) to the outcome of the integration process. For example, some studies suggest that change programs presented as radical departures often flounder because they are improperly framed by top management (Pondy & Hoff, 1988; Reger et al., 1994), but that even inappropriately framed change initiatives still can guide an organization if managed correctly by operational middle managers (Bamford & Forrester, 2003). Thus, it is essential to also examine how clinical management deals with the post-merger integration process if we are to understand critical factors that may advance or obstruct the achievement of intended goals following a hospital merger.

It is not self-evident, however, that management alone has a central role in the post-merger integration process. In professional service firms (see Section 2.1.6), merger research clearly points out that employees are critical to the development and outcome of integration processes (Empson, 2000, 2001; Greenwood et al., 1994; Löwstedt et al., 2003). Particularly in health care, it has been shown that professionals typically initiate/obstruct and control the pace and the direction of the integration process (see e.g. Fulop et al., 2002, 2005). Although professional organizations have unique characteristics that distinguish them from manufacturing companies in the traditional industry, merger researchers have largely neglected them (Löwstedt et al., 2003).

In addition, it is (obviously) important to study the consequences for clinical units in order to better understand why hospital mergers may succeed or fail. Still, most research on university hospital mergers largely focuses on the hospital as the unit of analysis (Kastor, 2003; Kitchener, 2002). This focus means that the integration process of clinical departments has not been adequately studied. To better understand the critical factors that may help or hinder clinical integration following a hospital merger, the third study focuses on clinical integration processes. The objective of the last study is as follows:

To examine clinical management's efforts to integrate clinical units following a hospital merger.

4 METHODOLOGY

4.1 STUDY DESIGN

4.1.1 Why a case study design?

Case studies have become one of the most common ways to do qualitative inquiry and are typically recommended as "the preferred strategy when 'how' or 'why' questions are posed, when the investigator has little control over events, and when the focus is on contemporary phenomenon within some real-life context" (Yin, 2003: 1). Such was the case of this research project. The case study design is also suitable when the focus is on describing the history of a past phenomenon and/or on understanding processes not yet thoroughly researched (Eisenhardt, 1989; Leonard-Barton, 1990*).* The phenomenon of interest for this study was the pre- and post-merger processes of large and complex organizations.

4.1.2 Why the Karolinska University Hospital merger?

Since case studies allow researchers to identify holistic and meaningful characteristics of real-life events, the need for a single overarching case study arose early in the research planning process. Given the desire to understand how and why real change processes evolve in large and complex organizations, the flagship merger of two publicly funded university hospitals in Stockholm, Sweden - the Karolinska Hospital and the Huddinge University Hospital - seemed a "purposive" way to study the phenomenon (Miles & Huberman, 1994). For several reasons, this merger is a highly interesting case that provides a substantively and theoretically critical example.

Firstly, in the field of health care, university hospital units and services are organized in large and complex systems in which many decisions are implemented across organizational boundaries and across occupational and professional groupings. Secondly, within this field, university hospitals represent a more highly complex organization than, for example, "ordinary" hospitals and traditional companies (Goldsmith, 1999). One reason is that university hospitals are embedded within multiple institutionalized fields that are constituted by competing sets of rules and norms concerning how participants should operate (DiMaggio & Powell, 1983; Kitchener, 2002). Thirdly, mergers represent a case of an extremely difficult change process in which multiple factors may cause failure more often than success (Cartwright & Schoenberg, 2006; Kavanagh & Ashkanasy, 2006).

Hence, an analysis of a merger of university hospitals within its real-life context would permit an in-depth exploration of the attempt to implement a highly complex change process in a highly complex change context (i.e. professionalized, public service settings). The analysis of such a merger in a field with "deep layers of competing institutional logics" would also provide a rare opportunity to examine a merger as a case of a radical change attempt similar to other radical restructuring tools applied in health care, such as Business Process Re-engineering (Hammer & Champy, 1993; McNulty & Ferlie, 2002, 2004). Finally, a single case design is eminently justified when the case represents an extreme/unique case or rare circumstance (Yin, 2003). For all these reasons, the case of the KUH merger was considered an excellent choice for the research purpose of this thesis.

4.1.3 Embedded case study design

Single cases are a common case study design. Yin (2003) describes two variants: those using the holistic design and those using embedded units of analysis. A typical problem with the holistic design is that the entire case study may be conducted at an abstract level, where operational detail of the phenomena is lacking. On the other hand, a major concern with embedded design is that the case study focuses only on the subunit level and fails to return to the larger unit of analysis. To extend the analysis, and thereby to enhance potential insights into the single case, this thesis uses the embedded design, which is the more complex variant of single case design. This means that several units of analysis were involved. The main unit is the hospital organization (represented by the executive management and the board) within a larger change context (represented by the regional government and the medical university), with the clinical departments as the smallest unit of analysis (represented by clinical managers and clinical staff members). Following literature's guidelines for sampling embedded cases, two embedded cases of clinical integration process were chosen based on maximum variation on the outcome variable (Denzin & Lincoln, 2000)[ix]. Each case represents two formally merged clinical departments (four clinical departments in total) of the same clinical speciality from each hospital site pre-merger (i.e. KH and HUH).

4.2 DATA COLLECTION

4.2.1 Interviews

Because the interview is considered one of the most important sources of case study information (Yin, 2003), interviews were used as the main data source for the three studies in this thesis. When existing theory or literature on the phenomenon studied is limited, interviews with open-ended questions are highly recommended (Hsieh & Shannon, 2005) rather than questions derived from a pre-existing theory. Following the strong recommendation to conduct guided conversations with a fluid stream of questions rather than rigidly structured queries (Rubin & Rubin, 1995), open-ended interviews were conducted instead of working from a predetermined list of questions. This meant that a core set of questions, with the overarching topic of "the merger" was posed to all respondents. Other questions, not specified in advance, were only asked if they seemed useful (Ibid.).

This approach meant that the interviewer had two jobs throughout the interview session: (a) to follow the line of inquiry, as reflected by the case study protocol, and (b) simultaneously to pose non-threatening questions that would elicit unbiased answers. This approach also allowed the collection of rich descriptions and concrete stories about organizational life, which Czarniawska (1997) argues is important for capturing and understanding the uncharted territories of organizational phenomena, such as in this case. Quotations from the interviews are mainly used in the thesis to illustrate important findings and to give the reader a direct link to the rich raw data on which the analysis rests. According to Yin (2003), respondents may also suggest other persons to interview, as well as point to other sources of evidence (e.g. documents). The more a respondent assists in this manner, the more the role may be considered one of an "informant" rather than a respondent (Yin, 2003). For example, the initial sample of interview respondents in Study I, suggested other key people who had insights into or had partici-

pated in the pre-merger process. These interviewees are accordingly identified as "key informants" in Study I. Each interview generally lasted between one and two hours. The same interviewer (the thesis author) conducted all interviews in face-to-face meetings in the interviewees' natural work settings. In total, 57 individuals were interviewed.

4.2.2 Documents

According to the methodology literature, documentary information is relevant to every case study topic (Yin, 2003). Numerous documents were therefore collected for all three studies. These were public documents (annual reports, meeting minutes, questionnaires/surveys, public inquiries, budget data, media reports, web pages, announcements, progress reports, newsletters, etc.) and non-public documents (notes, performance measures, memoranda, letters, internal presentations, decision-making data, e-mail messages, etc.). Documents must be carefully treated in the research process since they may not always be accurate (e.g. newspaper articles). Therefore particular care was taken in the interpretation of the documentary evidence in order to make certain that it was not prepared for some specific purpose (other than this research). Documentary data is particularly essential for retrospective reconstruction of the case history of a past phenomenon such as in Study I. Documents also help to verify key information expressed in individual interviews such as financial performance, formal goals and outcomes as well as the organizational structure, vision and strategic plans, etc. In fact, Yin (2003) claims that in case studies the most important use of documents is to corroborate and augment evidence from other sources (i.e. triangulation).

4.2.3 Observations

Observational evidence often provides useful additional information about relevant behaviours or environmental conditions, especially if the phenomena of interest are not purely historical. An essential requirement is that the observations take place in natural settings and not in experimental ones. Because the interest of Study II was to examine the work and dynamics of executive management in real-life, several field visits were made to the relevant site. Specifically, the investigator (the thesis author) participated in top management's weekly meetings and lunches during 2005 and 2006. This observation was of a *non-participant* nature because participant-observation may produce potential biases (see Becker, 1958). Also, the observer may lack the time to take notes and the opportunity to work as an external observer, as a good observer must. A direct non-participant who watches and records the top management in action obtains important data on several topics such as group dynamics and the handling of unexpected managerial challenges (e.g. in this research, the reluctant dismissal of a clinical Director). These observations were also useful in verifying opinions expressed at individual interviews about management's work logic and the progress of the post-merger process. When analysing managerial work, it is important to balance what people say they do (espoused behaviour) in individual interviews against what they actually do (observed behaviour). The observations permitted the recording of actual behaviour rather than espoused beliefs.[x] In total, 24 hours of top management meetings were observed (Study II). In addition, some observational data from informal sessions (e.g. lunches and breaks) were also collected.

4.2.4 Time period

Overall, retrospective data (Study I) as well as data in real time (Studies II and III) were collected across the organization as a whole (Study I and II) and from the clinical departments included in the two embedded cases (Study III). Taking the studies together, this thesis reports on the pre- and post-merger processes of the KUH merger between the years of 1995 and 2007. Collection of research data was concentrated to 2004 and 2007, which covered the three-year period the regional government gave the top management to fulfil their formal merger assignment. This period also coincided with the duration of the top management group analyzed in Study II. In 2010, Study III was complemented with data to get long-term indications on the clinical integration status six years post-merger.

4.3 DATA ANALYSIS

4.3.1 Data structuring

For the three studies, a specific step-by-step procedure was used to structure the empirical data. This process is briefly described next. [xi] Firstly, a research assistant transcribed the interviews that had been recorded on digital audiotapes (into Word files), which were then exported to a database using the Qualitative Research Software "NVivo 7.0". The thesis author read the interviews and the documents iteratively to obtain a sense of the whole (Tesch, 1990). Secondly, the data were read word by word to derive themes. This was done by first highlighting the exact words from the text that appeared to capture key thoughts or concepts, and then by analysing the first impressions. Thirdly, this process continued by assigning labels to themes that reflected more than one key thought or concept. These came directly from the text and became the initial coding scheme. Finally, a tree diagram was developed in NVivo 7.0 to help organize these categories into a hierarchical structure. To address the internal validity of the data, references to observational and documentary data were also noted in NVivo 7.0.

4.3.2 Pattern identification

To identify empirical patterns, the data was searched for dominant themes. These were recurring themes that had been mentioned as important and formative to the merger process by several respondents and/or stakeholder groups independently of each other. Next, the dominant themes identified were coded and mapped into categories and subcategories based on how they related to each other. For example, by mapping themes and key events in chronological order the case descriptions of the pre- and post merger processes were reconstructed. During the entire process, the themes were iteratively categorized, revised and compared. Finally, the emergent categories were used to organize and group themes into meaningful clusters or patterns (Coffey & Atkinson, 1996; Patton, 2002). The pattern identification process also involved discussions with colleagues, who challenged and questioned the emerging themes/patterns in working towards agreement (Patton, 2002; Yin, 1999).

Although the identification of empirical patterns followed a similar procedure, one distinguishing aspect should be noted. For Study I and Study III, an inductive or data-driven approach was used for the identification process of dominant themes and empirical patterns. This is generally recommended when the aim is to describe a phenomenon and existing theory on the phenome-

non is limited (Hsieh and Shannon, 2002). This means that researchers avoid using preconceived categories, and instead allow the categories and names for the categories to flow from the data. For Study II, a combination of a data-driven (induction) and theory-driven (deduction) techniques was used (i.e. abduction). The rationale for using an "abductive approach" was the pre-existence of substantial amount of relevant literature that we could draw on (whereas the phenomena was considered largely unstudied in Study I and Study III).

4.3.3 Theoretical interpretation

The primary purpose for incorporating existing theories in this thesis was to develop a deeper understanding of the discovered empirical patterns/themes and also enable theoretical generalization. In Study I, the aim was to find applicable decision theories that might offer possible explanations of the pre-merger decision-making process. However, the search for applicable theories within the general management literature proved fruitless. Following discussions with colleagues, the neo-institutional take on decision logics seemed to be more relevant to interpret the empirical findings in Study I. Specifically, by using the neo-institutional concept of *action* and *decision rationality*, a theoretical explanation of the decision-making process and its outcome was allowed. In Study II, a combination of theories from the merger literature, change management and the neo-institutional concept of radical change was used to interpret and explain the patterns of executive work found. In Study III, empirical findings in the two embedded cases were discussed and compared against the merger literature as well as a wider body of change management literature. Overall, the literature was used to increase the understanding of identified empirical patterns and to externally validate the empirical findings (i.e. theoretical generalization). This also means that previous research and relevant theories are largely addressed in the discussion sections of the published articles (see enclosed articles at the end).

4.4 ETHICAL CONSIDERATIONS

In accordance with the Swedish "Ethical Review Act", ethical application for the research reported in this thesis was submitted to and approved by the regional board in Stockholm (Diarienummer: 2005/875-31). The "Ethical Review Act" applies to research on living people, as well as to research on the deceased, human biological material, and sensitive personal information. This research did not involve laboratory equipment, biological material or any other sensitive personal information.

The prime research interest was of organizational nature (i.e. merger processes). Hence the interviewees were asked questions regarding "the merger" as the overarching theme. Moreover, the interviewees were informed about the objectives and procedures of the interviews in advance. The voluntary nature of the interviewee participation was emphasized. All interviewees gave their informed consent. To protect the anonymity of the interviewees, fictitious names are used in the thesis. In the instances where the position of an interviewee is unique and therefore might be disclosed, the interviewee gave his or her consent to be featured in the case descriptions.

4.4.1 Competing interest

This study was commissioned and partly funded by the regional government (i.e. the Stockholm County Council), which is the owner of the studied hospitals. The study design and all research activities were independently created. Observations were reported orally to representatives of the Stockholm County Council on various occasions. All publications are the result of an independent research process.

Table 1: Methodology Overview

	Study I	**Study II**	**Study III**
Study design	Case study - Change context	Case study - Holistic organization	Case study - Embedded units
Phenomenon	Pre-merger decision-making process	Post-merger integration process	Post-merger integration process
Unit of analysis	Regional government	Hospital management	Clinical department
Time period	1995 - 2003	2004 - 2007	2004 – 2007 (+2010)
Data sources	Interviews Documents	Interviews Documents Observations	Interviews Documents
No. of interviews	35	22	22
Data analysis	Chronological reconstruction Manual coding Inductive approach	Chronological reconstruction QRS-supported coding Abductive approach	Thematic reconstruction QRS-supported coding Inductive approach
Data validation	Triangulation Member checking	Triangulation Member checking	Triangulation Member checking

5 FINDINGS

5.1 THE THREE STUDIES IN A NUTSHELL

Study	I	II	III
Objective	To examine how and why a decision to merge two university hospitals might occur in a public sector context.	To examine top management's work in implementing mergers defined as radical change initiatives.	To examine clinical management's efforts to integrate clinical units following a hospital merger.
Methodology	This study reports from the years 1995 to 2003. Based on extensive document analysis and 35 key informant interviews, the pre-merger process was reconstructed in order to identify empirical patterns, which were interpreted by applying neo-institutional theory.	This study reports from the years 2004 to 2007. Three sources of data collection were used: 22 interviews, observations and documents. An abductive approach (i.e. themes from the data and the literature) was used to reconstruct and analyse executive management's post-merger work.	This study reports from the years 2004 to 2007. Based on 22 interviews with clinical staff members from four clinics, two cases of clinical integration efforts were reconstructed and compared. The results were then discussed using the merger and change management literature.
Findings	Spanning nearly a decade, the pre-merger process developed from *idea* generation through *transition* to formal *decision*. The process took place on the *scientific* and *political* arenas. The stated merger motives were to enhance *research excellence* and to improve *economic efficiency*. By applying a neo-institutional perspective, the study finds that the initial phases were driven by *decision rationality*, (which is typical in political organizations) and that the final phase was driven by *action rationality*, which is typical in private business firms. Critical factors behind this major change of decision logic were *means convergence* that united key stakeholder groups, and a *politico-economic crisis*, which ultimately legitimized the controversial merger decision. The study shows that stated and/or economic drivers may not alone cause merger decisions in the public sector.	The study describes a *linear* planned top- down approach to change in which a series of disruptions occur. Hence, the study confirms the *limitations of the classic change strategy* to explain radical change in professional organizations. An important *paradox* is identified: initial managerial success seems to impair the change process further down the organization. This finding is contrary to merger literature's prescription. This study confirms that a transition to *convergent* change is a more likely outcome when a *radical change* initiative is attempted in an organization embedded in deep structures of professionalism. In professionalized settings top management appears to be limited: to *initiate* radical change and to get the role of a *scapegoat*. The study also reveals their difficult role vis-à-vis multiple stakeholders inherent in public sector.	The study identifies three critical factors that appear instrumental for the process and outcome of integration efforts. These are clinical management's 1) interpretation of institutional pressures 2) design of management system; and 3) approach to change. Obstructive factors are: 1) an unfiltered interpretation of the formal mandate from the top; 2) individual leadership; and 3) the use of a classic planned, top-down approach to change. Supportive factors are: 1) a re-interpretation of the formal mandate to include competing logics; 2) shared leadership in a "hybrid system"; and 3) the use of a an emergent bottom up approach to change within planned boundaries. These findings are basically consistent with the merger literature's prescriptions for professional organisations.
Originality	By taking a pre-merger perspective, this study offers a rare empirical account of a university hospital merger.	This study contributes to one important aspect of managerial agency that is rarely discussed in the literature.	This study adds to the limited body of empirical research on clinical integration following a university hospital merger.

5.2 A SUMMARY PRESENTATION OF THE THREE STUDIES

5.2.1 Case context

Health care in Sweden is the primary responsibility of 21 regional self-governing bodies – counties. Each regional population elects its regional assembly – the county council. The county levies a proportionate income tax on the population, which is the main source of health care funding. The financial contribution of the national government is approximately 10 per cent of total health care expenditures, and is typically allocated to health care providers as financial incentives to promote national health policy goals such as improving access to care or increasing patient safety.

Higher education is the primary task of national government. Universities, including medical schools, are government agencies, funded by the Department of Education. State research councils and private foundations award funds for research.

Stockholm County provides health care to a population of about 2 million people in the Stockholm region. In the early 1990s the County introduced a "purchaser-provider split". A health care board, composed of politicians who are appointed by the regional parliament, was assisted by a secretariat of administrators and medical experts. This board is the purchaser of health care. The County owns the health facilities, which are part of the County governance structure.

During the last decade the Stockholm County decision-makers have: opened up the health care market, increased competition by privatising County facilities, invited new private providers to respond to tenders and, most recently, removed barriers to market entrance and let the "money follow the patients" according to the patients' choices.

At the end of the 1990s the legal status of some County hospitals, including Huddinge University Hospital, was changed. These hospitals became limited companies, entirely owned by the County. As limited companies, the hospitals have a more independent position than the directly managed hospitals. For instance, the companies have boards of (non-executive) Directors who are appointed by the owner (regional government). The board Directors are health care experts rather than politicians.

In 2003, both Karolinska Hospital and Huddinge University Hospital were County facilities and part of the regional governance structure. Hospital executives were appointed (*de facto*) by the regional government, and decisions concerning investments and infrastructure were made by the regional parliament. Huddinge University Hospital had the legal status of a limited company. However, when the two hospitals merged, the KUH became a directly managed unit. Although a board of non-executive experts was appointed, the board does not have, in real-life, the legal rights and responsibilities of a limited company's board of Directors.

Karolinska Institutet, a government institution that educates physicians and a number of allied health care professions, is the major national provider of medical and health-related research, Based on national regulation, the Stockholm County and the Karolinska Institutet have signed a contract for mutual cooperation in the fields of health education and research. The County receives financial compensation from the national government for the additional costs of clinical education and research that utilise County facilities. A number of bi-partisan committees over-

see the cooperation. There are no formal organizational links between the Karolinska Institutet and the County.

The Stockholm university hospitals have traditionally provided "super specialty" care as well as "basic" specialised care in order to meet the needs of clinical education and research. These hospitals have had a major role in providing health care services to the population. Table 2 depicts some statistics on the size and activity of the hospitals in 2003 (pre-merger) and for the merged hospital in 2004 (post-merger) .

Table 2: Key figures of university hospitals

	KH (2003)	HUH (2003)	KUH (2004)
Turnover (€M)	560	455	1030
Staff	8362	6565	15 393
Beds	1045	1089	1700
Visits	845 018	611 962	1400 000
Discharges	59 998	46 787	104 361
Year established	*1940*	*1972*	*2004*

Study I: Logics of pre-merger decision-making processes – The case of Karolinska University Hospital

Introduction

On 9 December 2003, the Stockholm County Council took the formal decision to merge Karolinska Hospital and Huddinge University Hospital. The merger decision was considered controversial, complex and far from obvious. How could a decision considered "impossible" become possible?

Background

In the merger literature, researchers have recognized the *pre-merger decision-making process* as an important determinant of post-merger process and outcomes. Nevertheless, most of the merger research has focused on the *post-merger integration process*. This stronger interest in merger consequences has resulted in modest attention paid to merger antecedents, even though they explain why hospital mergers occur and also may shed important light on why most fail. As a result, the *pre-merger decision-making process* is a more or less a scientific "blind spot", particularly in health care. Although general conclusions have been difficult to draw, research shows that efficiency arguments continue to dominate contemporary merger prescriptions. Such prescriptions, according to several researchers, provide dangerous guides for participants in merger processes because they do not provide sufficient explanations for merger outcomes. Instead they urge merger research to be redirected to explain drivers and motives arising from conflicting goals in the decision-making processes. As a direct response to this call for more research on pre-merger processes, this study examines *how* and *why* a decision to merge two university hospitals might occur in a public sector context.

Methodology

An in-depth study of the merger between two university hospitals (KH and HUH) in Stockholm, Sweden, was used to investigate the *pre-merger processes* of the KUH merger. The data for this study consisted of 35 interviews with individuals representing the formal decision-making body (the SCC), the merged hospital (KUH), and the affiliated medical university (KI). In addition, extensive documents were collected. By identifying key events in chronological order, the case history of the pre-merger process was retrospectively reconstructed. Data consistency was cross-checked over different empirical sources (interviews and documents). To seek possible explanations of the reconstructed pre-merger process, empirical patterns were interpreted using neo-institutional theory.

Case description

The decision to merge HUH and KH was considered controversial, complex, and historically unthinkable for several reasons. First, the rivalry between the professionals at KH and HUH had historically been fierce, which had hindered any deeper clinical or research cooperation. Second, the conditions for a large restructuring decision in health care were far from optimal, because SCC had shifted political majority in every election since the early 1970s, which led to a repetitive series of short-term reforms and counter-reforms.

In 1995, the newly appointed KI president expressed his concern that this rivalry was damaging to the clinical research work and to KI's position in the international research community. In particular, the area of highly specialized care was considered to receive insufficient research resources because KH and HUH competed for the same scarce patients in the Stockholm region. Inspired by how Johns Hopkins Medicine in the USA had united the three-partite mission of university hospitals (clinical care, research and education) under the same umbrella organization, the KI president began promoting the merger idea within KI, a vision he called "Karolinska Medicine". Because the merger topic was considered taboo, neither the research community nor the political community supported the idea for several years.

Following the election in the fall of 2002, after a new political majority took office in the SCC, it became evident that there was a significant budget deficit. This situation encouraged the KI president to propose the merger to the SCC politicians. It was argued that the merger would lead to cost savings as well as strengthen KI's research position. Still no action was taken.

When the Stockholm Administrative Court (based on an appeal by two citizens) unexpectedly rejected the SCC's unbalanced budget proposal on August 22, 2003, a new budget in balance was required "immediately" if the SCC was to avoid falling into "receivership". As a result, the HUH-KH merger idea was revived as a way to provide the largest cost savings in the budget proposal. Due to the extra-ordinary circumstances, much of the pre-merger work was prepared among few people in closed rooms. Hence, the political opposition claimed that the process was not being conducted in a "democratic way". Although the political opposition made an effort to engage the media, stronger emotions from the public rose against the proposal to close two local emergency wards. The endangered merger proposal was secured when a political compromise was reached that saved the two emergency wards. The decision to merge HUH and KH was taken by the SCC on December 9, 2003. The budget proposal with the merger as the largest saving passed by the narrow margin of 73 to 72.

Findings and discussion

The pre-merger process progressed from *idea generation* (nearly a decade) through *transition* (one year) to a *formal decision* (three months). The process took place in both the *scientific* and *political* arenas. The identified motives were to achieve *research excellence* and to produce *economic savings*. Hence the study identified three phases, two arenas, and two merger motives. Driven by research excellence, the KI president generated, promoted and tried to anchor the merger idea in the scientific community during the first pre-merger phase. During this transition phase, an economic crisis in the region allowed the president of KI to promote the merger idea among the formal decision-makers in the political arena i.e. the SCC. In informal meetings, key actors from both the scientific and the political arenas discussed and were united by the idea that a merger could be used to achieve both research excellence and economic efficiency. However, an unexpected disapproval (verdict) of SCC's budget proposal triggered a politico-economic crisis, which reduced the merger benefits to a strict focus on large and quick savings.

From a neo-institutional perspective, the first two phases were driven by *decision rationality*, which is typical for political and academic organizations, whereas the final phase was driven by action rationality, which is more typical for private firms. Critical factors behind this fundamental change of decision logic were an *economic crisis* and *means convergence*, which solved conflicting goals and united key stakeholder groups. The definitive shift to a "pure" action rationality was however not completed until a critical incident (the budget disapproval) caused a crisis in the political arena, which justified the *action rationality* driving the last pre-merger phase. The findings of two stated merger motives and an unstated political driver, suggest that there may be other motives than stated financial arguments for mergers in public health care. The finding of research excellence in Swedish studies of university hospital mergers should also modify the picture of the financial driver being the sole stated motive as reported by US studies.

Implications

The conclusion is that a change of decision logic from decision rationality to action rationality may promote reaching decisions in large and complex issues in a public sector context. Given that merger researchers generally point to the pre-merger process as a potential determinant of merger decisions, a natural implication for future research would be to study the post-merger integration process following the pre-merger process within the same case context.

Study II: Executive management in radical change – The case of the Karolinska University Hospital merger

Introduction

In the beginning of 2004, a new top management group took official charge of the newly merged KUH. The group immediately began working rapidly and pro-actively to achieve the regional government's change ambition, aiming at substantial cost reductions. However, by 2006 the group's motivation and enthusiasm had decreased. Eventually the group withdrew its original plan and the Director left the organization. The new Director reduced the management group and initiated incremental change projects within an already existing structure. How and why did the radical change ambitions turn into an incremental change process?

Background.

The concept of radical change, or "Big Bang" as it is sometimes evocatively known, covers quite dramatic organizational changes – and a merger between two university hospitals clearly fits into the kind of restructuring that has the potential to materialize radical change. The role of executive management in radical change is however very controversial. Functional theorists suggest a classic top-down approach that offers managers prescriptive techniques promising transformational change in two to three years. This research stream assigns the individual leader a pivotal role, for example, as an authorizer, visionary and motivator. Other scholars highlight the critical role that political negotiations between multiple stakeholders play in shaping the outcomes of change processes. The classic functional approach has been heavily criticized because it assumes "linear consequentiality" between top management's actions and the outcomes of the change process. However, an alternative approach largely fails to explain what role top management actually plays in real change processes. Thus there is a research need to further examine the work and role of executive management in mergers as a proxy of radical change.

Yet there are few studies that examine top management's post-merger work, particularly in health care. To contribute to this limited stock of empirical work, this study examines the work and role of executive management in merging two university hospitals. The aim is to shed light on critical factors that may advance or obstruct management's post-merger efforts in public sector health care. The objective is to examine top management's work in implementing mergers defined as radical change initiatives.

Methodology

This study reports from the period from the beginning of 2004 to the beginning of 2007, which covers the timeframe the new top management was given to fulfil the formal merger mission i.e. year 2004 to 2006. This three-year period coincided also with the duration of the top management group analyzed. Data was collected from 2005 to 2007. Interviews were conducted with all eighteen members of the new top management group and with four hospital board members. Top management meetings were observed on different occasions (24 hours) and numerous public and internal documents were collected in addition. An abductive approach was used to analyze the reconstructed case.

Case description

Following the decision to merge HUH and KH, the regional government (SCC) appointed a hospital Director who had a career background in private industry. This study describes the series of management actions and events that occurred in the first three years, where merger is seen as a radical change attempt. The new hospital Director recruited a management team who was loyal to her and to her managerial approach, which contributed to a strong cohesion within the group during the first post-merger year. The Director immediately prioritized handling the potential problems that might result from horizontal tension between the two hospital sites by, for example, addressing logo and branding issues early on to seek acceptance of a new and unified hospital. The Board, hired management consultants, the affiliated medical university (KI) and the Stockholm County Council expressed their support for the Director's approach to change. Under the "strong" leadership of the Director, the management group was driven by a strong focus on mandated cost savings. Due to the rigid deadlines of the merger mission, rapid decision-making, closed-door meetings and a perceived high degree of control portrayed the group's working mode. The executive work, which initially focused on internal administrative tasks, resulted in a number of "small wins" in which the mandated cost savings for the first year were achieved and even exceeded.

After the "jump start" in first year (2004), top management started to work aspects related to the clinical departments. The objective was to solidify the commitment to the hospital's strategy and implementation plans among doctors and nurses. However, almost immediately the clinical staff voiced their opposition, and the protests quickly spread throughout the entire organization. The Director had not anticipated this opposition and, therefore, was frustrated by the amount of time required to deal with it in personnel meetings. The situation worsened when several doctors contacted the media as a way to influence and change the management agenda. Without a contingency plan, the hospital Director was forced to respond to the media. She felt that the staff members who had made their complaints public through the media were deeply disloyal. The second year (2005) was described as "total war" between management and staff members. The division managers in the group, who all were doctors, became increasingly torn between their loyalty to their medical colleagues and professional values on the one hand, and their loyalty to the hospital Director and the managerial values on the other. When an emergency clinic was threatened with closure, outspoken protests arose among the staff and in the media, causing many division managers to question their loyalty to the Director and their merger mission. Eventually the management split in two groupings: (1) those with private industry, administrative backgrounds who remained loyal to the Director and the formal mission; and (2) those with public sector medical backgrounds who experienced awakened loyalty to their medical colleagues and clinical care.

In the beginning of the third post-merger year (2006), the political opposition entered the ongoing battle between the top management and the doctors. With an eye on a general election soon coming up, the political opposition publicly criticized the hospital Director for having neglected patient care and focused too much on cost savings. As a response to the criticism and the negative press, the Director declared the third post-merger year a "patient safety year." Otherwise, the top management group grew passive. No new activities, plans or merger-related actions were initiated. After a new political majority was elected, the hospital Director was replaced. The new hospital Director, physician by training, re-organized parts of the hospital management and launched a clinical process improvement initiative by employing a step-by-step approach.

Findings and discussion

In 2004 the new executive management had a "jump start", when the management team was successfully formed with high internal cohesion and the economic goal for the first post-merger year was achieved and even exceeded. In the second post-merger year (2005), however, the team "hit the wall" as it was challenged by escalating criticism from medical staff. In the beginning of the third year (2006), the top management group "ran out of steam" as members withdrew, and no new merger activities were introduced. In terms of competing logics, the executive work was driven by business managerialism in year 1, but got challenged by medical professionalism in year 2, and in year 3 medical professionalism superseded business managerialism. A new hospital Director initiated incremental change projects for selected parts of the organization. Thus, a radical change attempt transformed into convergent change three years post-merger.

Using change management terminology, the study outlines a classic top-down approach to change with a series of unexpected disruptions. The limitations of functional theorists' linear approach to radical change are therefore evident in this case. The study identifies an important paradox: contrary to what is predicted by the merger literature, initial managerial success seems to impair rather than promote the subsequent change process further down the organization. In particular, management fell prey to the conflict between the competing value systems of managerialism and professionalism, which was manifested by the growing tensions with clinical staff. A likely explanation for these managerial shortcomings is the high spirit within the group that followed the success of the first post-merger year. This, and several other factors (such as the strong focus on economic and administrative issues, isolation of management team members from their clinical constituencies and surrounding support from external stakeholders), may explain why the management's ability to recognize the complexity of the change context and thereby better understand the challenges ahead was diminished. This study confirms that "small initial wins" may in fact cause managerial hubris that impairs subsequent post-merger work. The study also reveals that even if the managerial agenda has the strong support of decision makers (i.e. SCC) and other stakeholders (e.g. the Boards, the medical university etc.), opposing value system and resistance among professional staff are easily triggered causing radical change attempts to stall. Hence the role of top management switches from being initially proactive to becoming reluctantly reactive during the process. Top management is the primary target of complaints and criticism and is therefore unwillingly forced into a scapegoat role. Consequently, the emotional and professional costs for senior managers are high, especially for doctors in manager positions (i.e. hybrid professionals). This study confirms that the prospects of achieving radical change are very limited due to deep structures of clinical work embedded in health care

Implications

Technological change, increasing market pressures and political programs introducing patient choice require health care organizations to adapt and change quickly. As shown earlier, a classic top-down approach to change seems to have low prospects of accomplishing organizational transformation in health care. To avoid the risk of managerial hubris (created by "small wins"), top management also needs to recognize the complexity of post-merger processes in settings with multiple stakeholders and competing institutional logic, such as in public sector health care.

Study III: Managing clinical integration – A comparative case study in a merged university hospital

Introduction

Following the amalgamation of top management and consolidation of administrative functions at the KUH in 2004, all newly appointed heads of the clinical departments with duplicating units at the two sites were given the same assignment: to integrate the units within the same medical specialty into single a entity under a common management structure and reduce costs. By 2006, this clinical integration had failed for Department X, but succeeded for Department Y. How can these different merger outcomes be explained?

Background

Since clinical departments are the units providing patient care and service delivery, a hospital merger will remain incomplete unless integration is achieved on that organizational level also. Yet most merger research focuses on the hospital as the unit of analysis, leaving merger consequences for clinical departments by and large unstudied. Moreover, the literature emphasizes that it is important to examine how operational middle management deals with those complex change processes in order to identify, *de facto*, the factors that advance or obstruct post-merger integration at the level of service operations. However, very few merger studies look specifically at the role of middle management in post-merger processes. This research gap is even more evident in the study of mergers in health care. To contribute to the limited amount of empirical research on merger consequences for clinical units, the objective of this study is to examine clinical management's efforts to integrate clinical units following a hospital merger.

Methodology

For this study two embedded cases of clinical integration efforts that had produced remarkably different outcomes were compared. Each of the studied departments (Department X and Department Y) consisted of two original departments of the same specialty at each site. The study is based on 22 interviews with members of the clinical staff (i.e. physicians, nurses, secretaries and clinical managers) and on document studies. 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). The 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 hospital merger. Data were collected in the years 2004 to 2007. This was complemented with some data from 2010 for the purpose of examining the status of integration six years post-merger. After both cases were reconstructed, they were compared in order to establish possible explanations for their different outcomes. The empirical patterns were then compared with previous studies and relevant organizational theory.

Case description

Following the successful integration of top management and initial consolidation of administrative functions at HUH and KH, the work of combining the duplicate clinics in these two pre-merger hospitals started in the spring of 2004. The plan was to reduce 125 clinical departments to 74. The executive management delegated identical assignments to all clinical management: to reduce costs by 10% and to integrate the original pre-merger departments at each site into single departments, each with a common management. It was this clinical management's task to work out the details of the planned amalgamation. This study describes two cases – one suc-

cessful, the other unsuccessful – of the formation of merged clinical departments. The aim is to explore what critical factors that may advance or obstruct clinical integration efforts following a hospital merger.

In the "unsuccessful" case, a clinical manager, with a specialist's license in the specialty of the department, was recruited externally by top management. He exercised delegated powers from top management and acted according to the adopted managerial agenda (i.e. initiated large, rapid, top-down changes). As the staff at one of the clinical units had suffered from poor leadership previously, they felt that this approach was appropriate. The other clinical unit had had a strong and popular leader, and protested vividly against the clinical manager's "dictatorial" style. The conflict escalated when external events such as the political decision to close both an emergency unit and an elective care ward affected these clinicians negatively. The clinical staff eventually forced the new clinic manager to leave, who became a scapegoat of the merger. After a long and troublesome search, a new clinical manager from a private hospital was appointed new formal manager. In the meantime, senior physicians at each site took over the operational leadership informally, and were later also appointed site managers in practice. Three years post-merger, an additional management level had been added to the departmental structure contrary to top management's goal of reducing administration levels and costs. Perhaps most significantly, physicians and nurses from both sites perceived the distance as "the perimeter of the earth minus 30 km". Six years post-merger, the situation was reported to be status quo.

In the "successful" case, the two clinical managers at each site formed in effect shared leadership "in tandem" from the very beginning. One of them was formally appointed clinical manager and the other worked as his deputy. They showed responsiveness to opinions from senior physicians. The amalgamation process was discussed with staff, and constituted a bottom-up process. Since they suspected a latent "horizontal" tension between the professionals at the two sites, both clinical managers attended all meetings together, and made sure to listen to all views at every meeting and "anchor" their decisions. Eventually, the deputy manager was able to return to his position as a specialist physician. The tandem leadership was also supported by an informal leader, a professor who forcefully emphasized the benefits of the merger in terms of improved conditions for research. By placing the clinical everyday work in an international scientific context, the professor encouraged all staff categories of the two sites to collaborate and integrate with each other across hospital borders as a way to achieve research success, which even contributed to spontaneous integration. In practice, the clinical manager and the professor defined that they had two constituencies to serve: top management "upwards" and clinical staff "downwards". By dividing these managerial duties, the professor took the strategic role as the visionary of the merged department "downwards", whereas the clinical manager dealt with the economic and operational issues on a daily basis, including reporting to hospital management "upwards".

Both the 10% cost savings and an integrated department with a common management were achieved in the time specified by the assignment. Staff and manager turnover was low, and group cohesion was reportedly strong. Three years post-merger clinical staff members reported that they belonged to the same clinical department and shared the same vision driven by research excellence. Six years post-merger, the situation was still reported as satisfactory with the same management constellation of a formal clinical manager and an informal professor running the department.

Findings and discussion

Whilst acknowledging that multiple factors may lead to success or failure post-merger, the comparison of the two cases identified three managerial factors that seem to have contributed to the remarkably different outcomes. These factors were the new clinical managers' different 1) interpretation of his formal mandate, 2) design of the middle management system, and, 3) approach to change. Factors that hindered integration were a sole attention on the formal mandate from the top management, leadership based on one formal actor, and the use of a planned top-down approach to change. Factors that facilitated integration were a dual attention to two majors stakeholders (top management and clinical staff), shared leadership between multiple actors, including an informal leader, and the use of an emergent, bottom-up management approach to change within the planned assignment. These findings are further discussed in this section.

The "unilateral" orientation towards a "pure" managerialism of the clinical manager in the "failed" case was somewhat surprising, since research shows that physicians who become managers usually maintain a firm identification as medical professional even in an intense managed care environment. His attention to the requirements of the medical professionals occurred only when their trust in him was already severely damaged at one site, which eroded the necessary capacity-for-action needed to shift change strategy. In contrast, the clinical manager in the "successful" case chose to "serve two masters" from the beginning i.e. the management and the professionals. In other words, this clinical manager re-interpreted his mandate in a way that accorded better with the actual context of competing institutional logics, which formed the basis for his actions including the design of a management constellation and approach to change.

Although previous research clearly points out difficulties in avoiding negative effects when integrating clinics, the study shows that the predicted danger of horizontal tension between merging entities can be met through shared leadership, including tandem leadership between two "equals". To handle the vertical tension between managerialism and professionalism, however, an informal leader (e.g. the professor) protected the professional arena and demonstrated research success as an aligning force across the two sites. The formal leader took responsibility for the administrative arena and thereby shielded the professional arena from institutional pressure from "above". This division of responsibility resembles the decoupling strategy often found in politicized settings. It also demonstrates a separation of the challenging function for clinical managers to balance dual and often conflicting needs and demands of both the organization and the medical professionals. The successful use of a shared leadership suggests that an overemphasized reliance on a "strong individual leadership" (typically recommended by the traditional merger literature), cannot be assumed for management of complex change processes. The useful division of the clinical management function might actually call for a shared clinical leadership where each actor has the *main* responsibility for one "pure" arena (professional or administrative) rather than one "hybrid professional" being responsible for balancing two competing logics.

In line with merger prescriptions for professional organizations, an incremental and bottom-up approach was more successful than the planned, top-down approach. Merger research on professional service firms confirms that managerial efforts imposed in a planned top-down manner may cause professionals with valuable knowledge and skills to leave an organization, thus eroding potential merger synergies. However, a closer look at the "successful" case reveals that the

emergent bottom-up change took place within planned boundaries set by the executive management. This finding reflects the more recent research stream that combines planned and emergent change. Taken together, the findings in this study basically agree with literature's prescriptions for successful change management of mergers of professional organizations.

Implications

Although previous research clearly points to the difficulty of avoiding negative effects when clinics integrate, the "successful case" in this study shows that merger pitfalls to a certain extent can be avoided when inclusive management practices are employed. In order to achieve successful clinical integration it seems important that middle managers are bold enough to make to re–interpret their formal mandate, to design a management system which involves informal leaders and introduce changes in a consultative process. Shared leadership seems to have advantages over individual leadership especially when striving for clinical integration.

6 DISCUSSION

6.1 INTRODUCTION

University hospitals are large and highly complex organizations. They are said to be perhaps "the most complex organizations in human history" (Peter Drucker, cited in Goldsmith, 1999: 150). In addition, mergers involve a difficult change process in which multiple factors may lead to failure more frequently than success (Cartwright & Schoenberg, 2006; Kavanagh & Ashkanasy, 2006). Therefore, a university hospital merger is inevitably a highly complex event. In this thesis the general aim is to increase our understanding of challenging change processes at large and complex organizations, specifically those processes in a merger of two university hospitals.

The three studies of this thesis dealt with the Karolinska University Hospital merger. Both pre- and post-merger processes and different organizational levels/units were analysed. Among other things, this approach helped us to understand: how a merger that was considered "impossible" became possible (Study I); how and why top management's intended ambitions resulted in an unintended convergent process and dysfunctional outcomes (Study II); and why considerably different merger results were produced by the two embedded cases of clinical integration efforts (Study III). Together, the three studies explain how this process and outcome evolved through a non-linear, unpredictable and complex interplay between external and internal factors and actors.

While an in-depth analysis and a detailed discussion of the critical factors affecting and explaining the merger process and outcome are presented elsewhere in the thesis (for details, see the separate studies), the aim in this section is to present a holistic view of the merger process by "putting the pieces together" based on the following procedure. (1) First, a quick overview of the case is given. (2) Second, the merger motives are discussed in relation to previous research. (3) Third, the merger outcomes are discussed in relation to relevant literature. (4) The next section examines plausible explanations to the merger process and outcome. This is done by discussing five central dimensions of the merger process by incorporating illustrative examples from the three studies and from the merger literature. The overall purpose is to shed light on the critical and complex link between the process and the outcome of that process. In other words, this section links to the core of the theoretical school within which this thesis is positioned: the process school. (5) The next section points out the thesis' main findings and contributions to merger research. (6) which is followed by a discussion considering methodological strengths and weaknesses. (7) Finally, in order to further deepen our understanding of complex change processes in professional, public sector settings, an attempt to formulate a theoretical contribution is done, which is rounded up with suggestions for future research.

6.2 CASE OVERVIEW

On 1 January 2004, the Karolinska Hospital (KH) and the Huddinge University Hospital (HUH), both located in Stockholm, Sweden, 30 km apart, merged to form the Karolinska University Hospital (KUH). The merger decision was controversial, complex and far from obvious. On 9 December 2003, the formal merger decision passed by a single vote in the Stockholm

County Council (SCC). The day after the formal merger decision, the SCC installed a non-executive hospital Board that appointed a new hospital Director. The new Director was officially in charge of KUH. To achieve a balanced budget by the next political election in 2006, the new Director was told to reduce expenditures by €70 million over the next three years (€10M in 2004; €50M in 2005; €10M in 2006). In the spring of 2004, all clinical managers were given identical formal assignments by the new top management: to reduce costs by 10% and to consolidate 125 departments with the same medical specialty into 74 departments with a new common management. In 2006, clinical integration had failed for Department X, but had succeeded for Department Y, both within Division Z. For the hospital as a whole, there was a surplus of €10 million in 2004. However, the second and third years post-merger (2005–2006) ended in deficits. In total, over the three-year period, the predicted cost savings for the merger were not achieved. Eventually the original implementation plan was withdrawn, the hospital Director left the organization and a replacement was appointed. This second Director reduced the management group and initiated incremental change projects within pockets of an already existing structure. Thus, the first chapter of the Karolinska University Hospital merger had ended.

6.3 MERGER MOTIVES

Both *stated* and *unstated* motives were given for the decision to merge KH and HUH. These motives agree with previous findings on hospital merger motives in the public sector (see e.g. Denis et al., 1992; Fulop et al., 2002, 2005). More specifically, the stated motives were anticipated improvements in *economic efficiency* and *research excellence*, whereas the unstated motive was *political gains*.[xii] Although the research excellence motive changed to a stronger focus on economic efficiency in the last pre-merger phase, it was clearly a stated motive at the time of the formal merger decision. The finding of research excellence as a stated motive coincides with previous Swedish (although limited) research on university hospital mergers (Brorström, 2004; Hallin, 2000).

It is unsurprising that research excellence and prestige is an important driver of university hospital mergers. Yet much of the existing research *de facto* reports that university hospital mergers (Kastor, 2003, 2010a, b; Mallon, 2003; Pellegrini, 2001) are driven by bottom-line economics and not by research concerns. Kitchener (2002) however noted that "cutting-edge research" was an *unstated* motive in the UCSF/Stanford hospital merger, whereas the stated motive was based on efficiency arguments because it "makes straightforward economic and operation sense. It reduces administrative overhead" (Kitchener, 2002: 407). This reduction to a strict focus on bottom-line economics is similar to the evolution of the pre-merger process in the KUH-case (Study I). Overall, studies from the US generally report that hospital mergers in general are undertaken with the aim of achieving improved or more stable financial conditions (see Bazzoli et al., 2004; Goddard & Ferguson, 1997). This aim is consistent with the dominant efficiency theory used to support mergers in the traditional industry (Trautwein, 1990). Because findings of research excellence reported by Swedish research (this thesis included), differ from US experience, stated motives for university hospital mergers may vary by context. Given the fact that US health care is to a far larger extent in private hands (including university hospitals) than Europe, one reason could therefore be that AHCs in the US are less insulated from market forces than university hospitals in Sweden (see also Kitchener, 2002, for similar reasoning).

As mentioned above, it is also evident from Study I, that mergers in the public sector may be driven by unstated motives (e.g. political gains). Drawing on parallels with previous research, the conclusion is that merger motives in the public sector may not necessarily result from stated (Fulop et al., 2002, 2005) and/or economic efficiency motives only (Denis et al., 1992). Consequently, in agreement with Trautwein (1990), current merger prescriptions – which are still dominated by efficiency arguments – are a dangerous guide for people participating in merger processes. In short, the findings in this thesis suggest that merger motives may be of different kinds (e.g. stated and unstated), may be several in parallel (e.g. economic efficiency and research excellence) and may vary by context (e.g. political drivers in the public sector). In particular, differences in institutional context seem to be instrumental in explaining identified differences in underlying drivers. Because current prescriptions are dominated by data from private sector settings, the suggestion here is that the general understanding of merger motives should be more nuanced (particularly for those taking place in public sector settings) and should take greater recognition of the institutional context.

6.4 MERGER OUTCOMES

The review of previous research (see chapter 2) shows that the outcomes of horizontal mergers are mixed, patchy and even contradictory. However, the bulk of the evidence seems to support the position that mergers are high-risk strategies (see 2.1.7). This seems to be particularly true in the health care area where research shows that most mergers fail (Andreopoulus, 1997; Blackstone & Fuhr, 2003; Mallon, 2003, McClenahan, 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).

In the KUH merger, the regional government (the SCC) issued a specific assignment to top management: to save €70 million (equivalent to 7% of the annual turnover) in the next three years. If the success of the KUH merger is evaluated purely in terms of whether these cost savings were achieved, it is a straightforward task to assess the merger outcome. Although the hospital Director and the Board thought the savings figure was "peanuts" compared to cost reductions typical of manufacturing industry, the KUH did not achieve these financial goals in the specified three-year period. Hence, the KUH merger outcome agrees with the existing research that shows that mergers typically fail in one or several dimensions.

Looking at the KUH merger in terms of its failure to achieve the three-year financial goals, various researchers might find support for their recurrent warnings about the "folly of merger mania" in health care (e.g. Andreopoulos, 1997; Goddard & Ferguson, 1997; Mallon, 2003; McClenahan, 1999; Todd, 1999). However, those studies assess merger outcome within the timeframe of 1 to 3 years post-merger. Consequently, this research, at best, measures the short-term effects of hospital mergers rather than the long-term effects. In the research of this thesis, certain non-financial aspects (integration status) of the merger were evaluated even six years post-merger.

The KUH merger presents a more nuanced picture of merger outcomes. Cost savings of €10 million were achieved in the first year (resulting in a surplus of €10 million), but the mandated €50 and €10 million cost savings were not achieved in the second and third years There was a "jump start" in the first year when the post-merger hospital administration reduced costs. How-

ever, this initial success was not matched in the next two years as various changes were implemented in the organization. This pattern is consistent with several studies that have found that successful consolidation of administrative functions occurs quickly among horizontally merged hospitals, but that clinical changes typically are not fully implemented even years after a hospital merger has been formalized (Bazzoli et al., 2004; Eberhardt, 2001; Lesser & Brewster, 2001; Wicks et al., 1998). For example, Fulop et al. (2002) report that the clearest source of potential savings from a merger is the reduction in the numbers of management board members. The finance managers they interviewed "were less convinced that other savings were achieved within the first financial year" (Fulop et al., 2002:4). The authors also point out that senior management seemingly had underestimated the amount of time and effort required by the mergers, resulting in the delay in service developments by at least 18 months (Fulop et al., 2002). In the KUH merger, the initial successful cost savings followed by failure confirms the results of these studies. In fact, KUH produced the single largest financial deficit of the regional health care consumption in the second year after the merger (KUH Annual Report, 2006).

Previous research reveals that the initial post-merger savings are quite limited. They tend to be small in magnitude (e.g. Connor et al., 1998; Lesser & Brewster, 2001), may simply represent movements away from prior inefficiency (Alexander et al., 1996), are quickly exhausted (Dranove, 1998), largely result from administrative savings (Eberhardt, 2001), and may simply be one-shot savings rather than reductions in rates of cost growth (Bazzoli et al., 2004). Fulop et al. (2002) also report that the cost savings for four mergers of NHS trusts were minimal (although they were not consistent for the four NHS trusts studied) and less than the estimated annual savings (£500 000). In the KUH merger, cost savings in the first year were equal to 2%[xiii] of annual turnover, which by industry standards is considered small for mergers. Again, given that most studies (including this study of the KUH merger) only examine financial results 1 to 3 years post-merger, this timeframe may be too early in the merger process to observe appreciable savings. This may be especially true if knowledge synergies are taken into account. For knowledge-intensive organizations such as pharmaceutical companies, it may take 7 to 10 years before merger synergies are realized (Birkinshaw et al., 2000).

In the KUH merger, both research excellence and economic efficiency were the stated merger motives. Thus any evaluation of the KUH merger ought to consider whether these goals were achieved. Given that the realization of research synergies may take as long as ten years, the evaluation as far as research excellence indicates a longitudinal study is appropriate. The longer the timeframe, however, the more difficult it is to attribute the achievement/non-achievement of research excellence to the merger, especially given the turbulent context of the health care environment (Fulop et al., 2002: 7). Furthermore, a problem is that researchers in general have difficulty in deciding on appropriate measures of research and clinical excellence (see e.g. Sowden et al., 1997).

Thus Department Y's successful integration of two clinical units that was achieved in the first years post-merger (including reported research synergies, cost savings and even spontaneous horizontal integration) is somewhat of an anomaly (see Study III). Consequently, the unsuccessful outcome of the failed clinical integration in Department X was according to previous merger research expected. Although the research of this thesis clearly identifies the difficulty of avoiding negative effects when integrating clinical departments (Bazzoli et al., 2004, Fulop et al., 2002, 2005; Kitchener, 2002), the successful integration in Department Y shows that merger pitfalls may be avoided and that task synergies and clinical integration may be produced even at

an early post-merger stage. At the hospital level, however, the research of this study supports previous key findings that report hospitals are able to quickly consolidate and integrate administrative functions-- albeit limited one-shot savings -- but clinical consolidation/integration is much harder to achieve (see review by Bazzoli et al., 2004).

6.5 PROCESS SCHOOL REVISITED

6.5.1 Pre-merger influence on post-merger work

Managerialism, which was the rationale for and action logic driving top management's post-merger work (Study II), can be traced to the final decision-making phase in the pre-merger process (Study I). Several key actors with various motives guided the pre-merger process in the beginning; in the end, the decision logic became a strict economic justification the SCC used to quickly legitimize the merger decision. Consequently, the SCC leaders specified short-term savings goals in the assignment they issued to the new hospital Director. In searching for a hospital Director, they looked for an individual who had a private industry background with experience with budgets and cost reductions. The appointed Director had been the HUH Director and also had held top management positions in the pharmaceutical industry. Having received the cost-cutting assignment for the next three years (2004-2006), the new Director immediately took actions to achieve those stated economic goals of the merger.

The more normative merger literature recommends that management delay working towards intended merger synergies (such as cost savings) until the staff members of the merged organizations have accepted each other fully (Graebner, 2004). This recommendation in particular seems to be critical for knowledge-intensive organizations (Birkinshaw et al., 2000). However, the results of Study II show that the first phase of the post-merger integration process was driven by an action logic based on "pure" business managerialism aimed at achieving early task synergies. Moreover, Study III shows that top management's economic savings goal (originating from SCC in the pre-merger process) influenced the formal mandate assigned to the clinical manager. The same cost reduction goal of 10% was given to all clinical managers. This goal was based on rough estimates rather than on a detailed analysis of potential synergies. This short timeframe of three years in the KUH merger did not agree with the normative literature on hospital mergers that claims an extended time period is needed to build trust, to obtain buy-in and to deal with the resistance from the professionals (Bazzoli et al., 2004; Fulop et al, 2002; 2005). Addressing operational tasks, especially at the clinical department level, should follow this lengthy time period of adjustment.

Although several merger researchers have recognized the *pre-merger process* itself as a potentially important determinant of the development and outcome of the post-merger integration process (Denis et al., 1992; Haspeslagh & Jemison, 1991; Jemison & Sitkin, 1986; Trautwein, 1990), there are very few studies that *de facto* describe the link between the pre- and post-merger processes. Data from the three studies of this thesis show that the executive management's formal mandate given by the political leaders in the pre-merger process strongly influenced the early integration work at all levels of the organization (i.e. by the effect of managerialism on top management work). The formal mandate effectively placed a number of restrictions on the work that was then passed on to the clinical department managers. By framing the merger mission to the clinical managers according to a strict business-managerial logic, the

manager in Department X (Study III) adopted a top-down approach to clinical integration, which contrasts to literature's recommendation for professional organizations. By synthesizing the three studies, the managerial logic adopted in by the clinical manager in Department X (Study III) could be traced back to the formal mandate given by the top management (Study II), which in turn originated from the regional government (Study I). Hence, the critical link between the pre-merger and post-merger processes is clearly recognized in this thesis.

6.5.2 Managerial hubris and managerial work

Although there may be multiple reasons that may explain why management failed to anticipate and deal with the conflicts with the clinical staff, one main reason that crystallized in Study II was managerial hubris i.e. a tendency to be overenthusiastic and overconfident, as predicted by Seth et al. (2002). This managerial hubris arose after the initial year when the cost savings were achieved. Several factors seem to have contributed to the high spirit.

First, the cost savings goal for the first post-merger year (2004) was achieved and even exceeded through administrative consolidations. However, research on hospital mergers shows that initial rationalization and integration of administration and other support activities are fairly straightforward because roles, responsibilities, and lines of authority are clear and duplicative functions are easily identified (Bazzoli et al., 2004). Research also posits that the lack of conflict and the presence of administrative hierarchies make initial consolidation achievable (Ibid). Again, these initial savings tend to be small in magnitude (Connor et al., 1998; Lesser & Brewster, 2001) and may simply be one-shot savings (Bazzoli et al., 2004). The results of this thesis clearly confirm previous findings of "small initial wins" The achieved cost savings for the first year were – as previously mentioned - relatively small by average industry standards.

Second, owing to the pressure of the strict deadlines imposed by the regional government, the management group worked intensively in closed-door meetings during the first post-merger year. A highly focused and intense work mode probably contributed to strong internal group coherence and the perception of tight control. In combination with support from other actors (such as the Board, the medical university and the political leadership) the management group may have experienced a false-sense-of-security (Vaara, 2001).

Third, early in the merger process the hospital Director was successful in horizontally integrating the management groups from the two merging hospitals (cf. Santala, 1996). The Director demanded unity and gave equal attention to both sites. These actions are consistent with the normative literature that advocates the necessity of addressing horizontal cultural differences at an early stage (Datta, 1991; Sales & Mirvis, 1984). Studies of university hospital mergers have also found that a main reason for failure may be attributed to horizontal tensions and clashes between top management and trustees at early stages (Cohen & Jennings, 2005; Kastor, 2003, 2010b). However, although the research claims that horizontal integration of top management is necessary for overcoming resistance between the merging organizations at later stages (Santala, 1996, Schriber, 2006), such integration may be insufficient, as explained next.

The hospital Director selected management group members and explicitly required loyalty to the Director and the organization i.e. physician-members were committed to a full-time managerial role. In making these selections, the Director wished to be accepted by those members

who had a medical background also. Her creation of a strong managerial culture and her emphasis on a commitment to the economic goals appear to have contributed to the quick and successful horizontal integration of the top management group (Santala, 1996). In other words, the suppression of professionalism as a working logic was necessary if the initial horizontal integration was to be achieved. Ironically, a suppression of professionalism (i.e. the requirement for successful horizontal integration) seriously impaired management's ability to anticipate and handle the vertical conflict between managerialism and professionalism that came to dominate the subsequent merger process. Paradoxically, a main finding is that a successful integration of the management group may damage rather than support integration further down the organization, which is contrary to contemporary literature prescription (see e.g. Santala). This resonates well with previous merger findings in health care (see 2.2.6), where most research shows that a successful initial consolidation of administration may not provide the basis for dealing with tougher issues at a later point, as posited by Shortell et al. (1994). To avoid the dangerous trap of managerial hubris that misguides top management (Seth et al., 2002), a true understanding of the multiple competing institutional logics inherent in hospital mergers is recognized as a more appropriate basis for executive work rather than "pure" managerialism.

6.5.3 Internal conflict between managers and professionals

Both Study II and Study III consistently reveal that the main post-merger challenge was the conflict between managerialism and professionalism at all levels of the organization (Kitchener & Gask, 2003). When management's planned post-merger work reached the clinical departments, problems arose. The post-merger work was quickly overshadowed by the clinicians' escalating frustration with the Director and the use of business logic to justify the merger. The failure of clinical integration (Department X in Study III) is partly explained by the fact that the department head adopted a managerial logic in his approach to clinical integration.

The professionals' firm resistance at both the hospital and clinical levels as observed in this study matches previous research on hospital mergers (Bazzoli et al., 2004; Fulop et al., 2002, 2005). This resistance is also consistent with general merger research on professional service firms in the private sector that shows that professionals typically control the pace of integration at all levels (e.g. Empson, 2000, 2001; Løwendahl, 2005). According to Greenwood et al. (1994), special challenges arise with integration in professional organizations largely because the leadership has limited control over the activities requiring mission-critical knowledge. The initiative for integration is said to depend on the level of the independent-minded professionals' trust in management and their will to integrate (Empson, 2000). For this reason, the research suggests that management refrain from deliberately planned actions in order not to destroy trust in management by such professionals (Graebner, 2004). However, despite the clinical staff's escalating mistrust of the management and their growing resistance to managerial actions, management at different levels at the KUH continued to implement top-down changes as planned (cf. Kavanagh & Ashkanasy, 2006). The effort to justify the merger with arguments based on professionalism occurred too late, when the trust in management was already severely damaged (Haspeslagh & Jemison, 1991).

This research reveals that the degree of conflict between managerialism and professionalism may vary over time, manifesting the "vertical" conflict in various ways. Because of the inner, strong cohesion within the top management group, the division heads i.e. the physician-

managers (see Montgomery, 2001 for more details on "hybrid professions") initially defended the hospital Director who had become the symbol of managerialism and a merger scapegoat. Hence, the competing logics were initially demonstrated as a vertical clash between the management group and the clinical staff. Further down the organization, problems with core clinical operations arose because of increased service disruptions (see also Fulop et al., 2002). Escalating conflicts forced the division heads to spend considerable (unscheduled) time dealing with the discontent in "unpleasant and tempestuous" staff meetings. The division heads soon showed divided loyalties. On the one hand, they were committed to the formal mission (managerialism); on the other hand, they were committed to their clinical staff (professionalism). Following the increasing pressure from medical colleagues, a split within the top management group occurred. Division heads with administrative background remained loyal to the logic of managerialism, and those who were physicians "retreated" to an earlier position primarily acknowledging the logic of professionalism. Several conclusions can be drawn from the conflict between these competing logics.

First, it is evident from our research that it is extremely difficult for an individual in a hybrid position to balance the dual logics of managerialism and professionalism that are inherent in many administrative positions in health care (Montgomery, 2001). Second, the professionals saw the division heads in the top management group as informal channels that could be used to influence the management agenda in favour of professionalism, apparently successfully. Thirdly, the intensity of the vertical conflict between managerialism and professionalism seems to vary over time and arenas, where the conflict seemingly increases over time as the merger processes comes closer to and interferes with core clinical operations (Bazzoli et al., 2004).

In conclusion, severe and escalating conflicts with the clinical staff forced management to abandon its original plan and instead (reluctantly) to address unanticipated and unscheduled actions, recognizing the loss of control in the now undirected, post-merger integration process. Based on these observations, it appears that the vertical clash between managerialism and professionalism is the main post-merger challenge in a hospital merger, not fully acknowledged in the existing merger literature.

6.5.4 External actors entering the conflict

External actors also influenced the post-merger integration process that was already the scene of conflict between the managers and the professionals. When the clinical staff went to the press with their various complaints, the media became involved in the conflict. The use of the media to influence a managerial agenda, points to the importance of being aware of "intra- and inter-organizational dynamics" inherent in public sector organizations (McNulty & Ferlie, 2002; 2004). The clinical staff's frequent allegations and inquiries channelled through the media forced the hospital Director to attend to problems that she might otherwise have devoted less attention to. She was frustrated because dealing with these problems took time away from internal affairs. She also became increasingly defensive since the media seemed to focus on her alleged managerial inadequacies.

The conflict between managerialism and professionalism intensified when another external actor entered the stage: the political opposition. Hoping to score election points, the political opposition allied with the professionals to jointly voice complaints in the media against the hospi-

tal Director. The charge was that she had focused too much on finances and not enough on quality of care and patient safety. Gradually, the professionals took over the management agenda by effectively using these external actors to their own advantage.

By the third year post-merger, external pressure forced management to change the agenda by prioritizing patient safety (i.e. professionalism) and to downplay the planned cost savings (i.e. managerialism) at least outwardly. Top management withdrew from the clinical arena, waiting for the storm to blow over. No new activities related to the original merger ambitions were introduced. Top management had to back away from its original strategy as a result of the external pressure from the media and the political opposition. In contrast to traditional merger literature, that reports that external factors do not notably affect management work in merger processes (Birkinshaw et al., 2000; Graebner, 2004; Larsson, 1990), Study II clearly reveals that external actors can shape both the post-merger process and the outcome through interaction with internal actors (i.e. the professionals). This complex interplay may even explain the transitions between the post-merger phases observed in the KUH merger.

Moreover, merger studies in private industry show that executive management pro-actively uses the media as an arena to interpret, explain and argue for the legitimacy of a merger to the public (Hellgren et al., 2002; Tienari et al., 2003). In this study the Director was unable to use the media to convey management's counter-defensive message. Instead, clinical staff members used the media pro-actively in efforts to reorient the hospital agenda from managerialism to professionalism, which clearly shows that the use of media in merger processes may vary by institutional context.

Leadership in public organizations is by definition a public concern in which the public, the media, and politicians are expected to debate, investigate, and criticize decisions and actions (Holmberg, 1986). This means that actions and decisions viewed as expressions of competence and loyalty in a private sector context might be viewed as expressions of incompetence and disloyalty in a public sector context, and vice versa (Ibid). Organizations in the public sector (such as university hospitals) are politically controlled and follow principles of transparency (e.g. free access to public records). In the public sector, political and external considerations are at least as important as the internal economic realities that typically frame the context of company mergers. Thus, top management in public sector organizations must realize that dealing with the media and the public should be considered as natural parts of their work and agenda.

However, when the medical professionals in this study contacted the media to further their agenda, the hospital Director and board members – all with private sector backgrounds – were dismayed by what they perceived as disloyalty. The division heads with a medical background, on the other hand, were not surprised, since they thought media attention was justified by the transparency logic of public sector organizations. The private sector vs. public sector issue is yet another competing logic that reveals the complexity of the process, while it also deepens our understanding for why the process turned out undirected and why unintended outcomes were produced, which again imply that merger processes seem to be highly sensitive to context.

6.5.5 Critical events triggering changes in logic

In Study I, the critical event of an *unexpected verdict* (the disapproval of the unbalanced county budget) triggered a political crisis in the regional government. The verdict set the stage for the controversial decision to merge the two university hospitals. Taking a neo-institutional perspective, we suggest that a change of decision logic -- from decision rationality to action rationality -- was crucial for the uncritical adoption of the merger idea to happen. Where once the merger had been considered impossible, it now became possible. Since decision rationality is usually found in public sector organizations, and action rationality in private sector firms, this change in decision logic may, therefore, be viewed as a change of institutional logic: from the public sector to the private sector. The political leaders confirmed this change. One politician described the final pre-merger phase as "like a merger in the business world".

In Study II, the *political decision* to reduce the capacity of the emergency department at one of the sites confronted top management in the second year post-merger. This decision had important ramifications as to the post-merger process. The division heads were already under stress because of the escalating resistance by clinical staff and because of the turbulent situation in general. While the division heads felt loyalty to the hospital Director and to the cost-cutting goals (i.e. managerialism), they also experienced an inner conflict stemming from their dual role as both manager and physician. This conflict increased when their medical colleagues complained openly about top management and the merger. Although several factors contributed to their change of logic, it seems that this political decision caused the division heads to finally switch their loyalty from the hospital Director and the management agenda (i.e. managerialism) to the clinical staff and their medical agenda (i.e. professionalism). This split within the management team triggered the last phase of the executive work, which was increasingly influenced by pressures from internal actors (division heads and clinical staff) and external actors (media, political opposition) advocating professionalism over managerialism. Three years post-merger, professionalism steered the executive work and had thus taken over the hospital agenda

In Study III, Department X was also affected when the same *political decision* as above hit the new clinical manager unexpectedly. This closure decision meant that high volume and emergency care would be reduced at Clinical Unit Xk. The political leadership (SCC) justified the decision with the argument that only rare and complicated patient cases should be treated at Xk. However, an earlier political decision to close a ward at Xk had already generated severe protests against the new manager by the clinical staff at Xk. A second critical event unexpectedly occurred about the same time – the Thailand tsunami disaster of 2004. The staff at the Xk unit "made a huge effort" to help the survivors, partly to demonstrate the necessity for maintaining the ward. Although department manager X tried to act on behalf of the clinical staff by impeding top management's closure decision, he was unsuccessful. When the ward closed, key staff members left, and the Xk unit "collapsed" into "complete chaos" due to inadequate staffing. The effort to change loyalty to the professionals came too late. Eventually, the clinical staff at Xk forced the new department manager to resign. Following his involuntary resignation, angry staff at the opposite hospital site (i.e. unit Xh) for the first time expressed their antagonism towards their colleagues at Xk. The Xk members however, continued to regard the Xh members as their medical peers and colleagues in their continuous battle against the management and the merger.

Although, the merger literature points to the horizontal tension between merging organizations as an early and perhaps main merger challenge, this example shows that the horizontal tension was triggered at a later stage by the resignation of department manager X. His resignation is traceable to the political decisions made by the regional government. Hence, these examples from Study I and Study II demonstrate that unexpected political decisions were the triggers for an uncontrollable chain of events, which, among many things, fuelled the mobilization of professionals. Ultimately this battle led to professionalism regaining its dominance over managerialism, which was manifested by top management's announcement of "patient safety" for the third year post-merger and by the discharge of the hospital Director that followed.

By "putting the pieces together" (i.e. the three studies), the picture below illustrates the pre- and post-merger processes in the case of the Karolinska University Hospital merger. In particular, the picture highlights the link between the preceding and the subsequent phase/process and also the multiple competing logics inherent in professionalized, public settings:

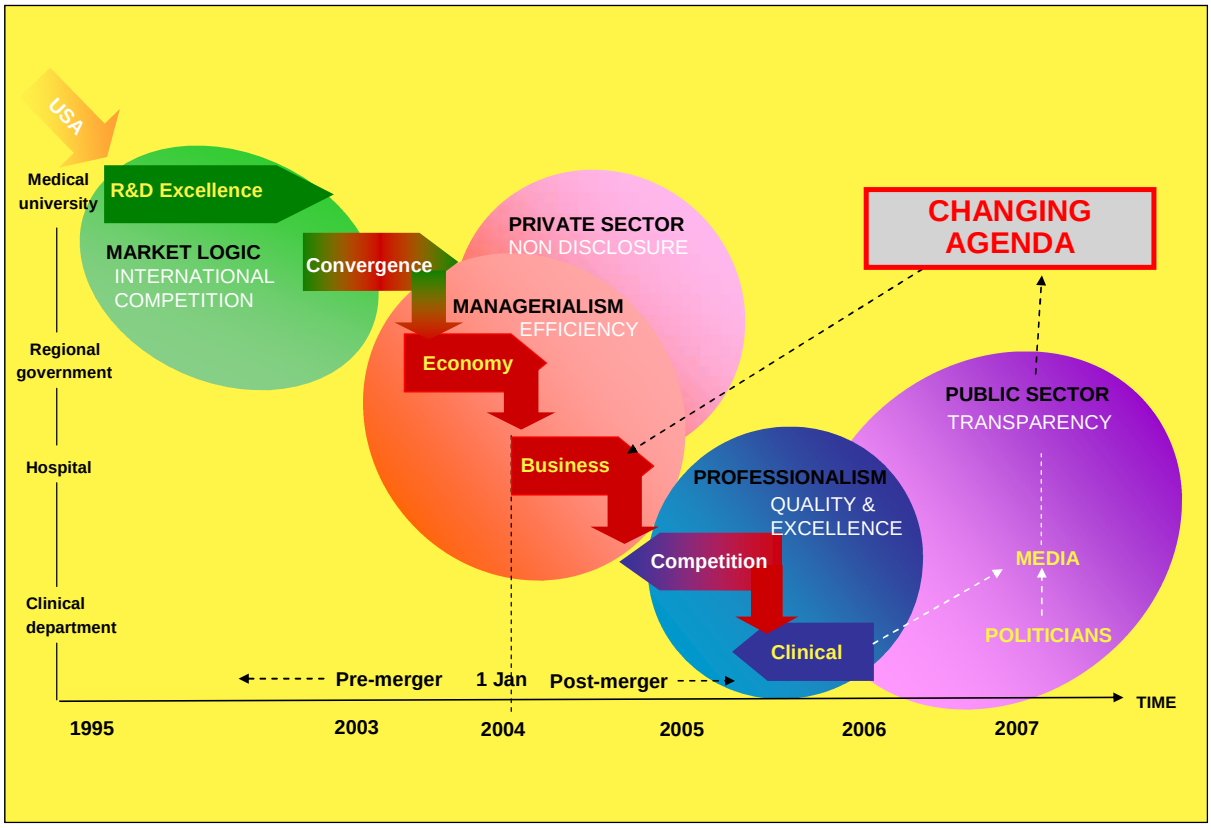

Figure 1: Pre- and post-merger processes in the Karolinska University Hospital merger

6.6 METHODOLOGICAL CONSIDERATIONS

While the organizational research tradition uses a wide variety of approaches, often with large overlap, a qualitative in-depth case study design was selected as the most appropriate approach for the primary goal of developing theoretical and empirical understandings of an unfolding merger process within its actual context (Yin, 1999; 2003). Overall, this method permits the verification and description of the critical link between the change process and the outcome of that process, which is the central aim of the process school in which this thesis is positioned.

The data collection process for a case study is more complex than those used in other research strategies (Yin, 2003). To ensure quality during the data collection process, Yin's (2003) recommended principles for maximizing the benefits of case study design were therefore followed. These principles are described next.

Use multiple sources of evidence (triangulation): A major strength in case study data collection is the use of many different sources of evidence although the collection process imposes a great burden on the researcher. This means that any finding in a case study is likely to be much more convincing and accurate if it is based on several different sources and methods of information. Data collection for this thesis was pluralistic in several ways. For example, it incorporated multiple stakeholder groups in both the pre- and post-merger process who were deemed relevant for the study of university hospitals (e.g. the affiliated medical school, the owner of the hospitals, the top management, etc.). However, Yin (2003) asserts that the most important advantage of using multiple empirical sources is that this method allows the researcher to develop converging lines of inquiry through the process of triangulation. Guided by this recommendation, three different methods of data collection were used: interviews, documents and observations.

Create a case study database: The main objective of a database is to allow the data collected to be readily retrievable for later inspection. All data collected for this thesis were stored in such a manner that other persons could retrieve the data efficiently at a later date. For example, the interviews were recorded on digital audiotapes and then transcribed and stored as Word files. In particular, qualitative research software was used (NVivo 7.0) to organize and categorize the data for later access. The interviews were archived by registering them by a number, time, place and category. Notes, which were taken at observations, were stored securely with interview files/tapes and documents, either in a locked storage or in digital format with password protection.

Maintain a chain of evidence: To increase the trustworthiness of the data collected, another recommended principle is to maintain a chain of evidence, since this chain allows the researcher to trace the process backward. For this thesis, all interviews/citations in the case study database were linked to key events, dominant themes, subcategories, categories and clusters. The software, NVivo 7.0, permitted tracing categories and subcategories to the evidentiary source (e.g. the interviewees). Reversely, all data in each category and subcategory were directly linked to the key source information, which in turn was cross-referenced to a database in Excel with information on the interview (e.g. day, time, place). In this way, the desired chain of evidence was maintained.

The inclusion of illustrative quotations from the interviewees in the case descriptions in the three articles allows the reader to link the empirical data to the study findings. A rich case description with quotations should also allow the reader to make his or her own interpretation of the data, at least to some extent. In this way, readers and scholars are encouraged to challenge the empirical patterns and theoretical interpretations suggested by the thesis author, given that a "purely" positivistic view (claims of one "universal truth") is refuted by the research tradition in which this study rests.

Throughout the study, the levels of trustworthiness were enhanced in several other ways. Apart from cross-checking data consistency (see e.g. Miles & Huberman, 1994), triangulation was used to search for rival explanations (see Patton, 2002; Yin, 1999). The search for non-corroborative evidence from alternative sources was conducted to reduce the influence of interviewer bias (see also "negative evidence testing" in Patton, 2002; Yin, 1999, 2003). In a further step to ensure trustworthiness, the interviewees were sampled from multiple stakeholder groups (e.g. administration, political majority, political opposition, the medical university, the hospital board) and professional groupings (e.g. managers, secretaries, physicians, nurses) at different managerial levels (e.g. regional government, top management, clinical management) and arenas (e.g. political, research, hospital, clinical). The aim of this sampling was to secure a broad spectrum of responses from relevant people whose perspectives might be complementary, conflicting or even contradictory (Hurley, 1999). In addition, validation was used in which drafts of the thesis articles were sent to available key informants, asking for their confirmation of preliminary findings and for additional data (see also "member checking" in Devers, 1999). Member checking was also used when group presentations were given to several respondents at the same time (e.g. the top management group) on different occasions.

It may be argued that the data for this thesis provide high internal validity but low levels of external validity. This issue was addressed by comparing and testing the research results against a wider body of relevant literature at all stages of the research process. In addition, several researchers were involved in the data analysis process to ensure the validity of the inference process. In the course of reaching agreement, this meant that scholars representing multiple disciplines extensively discussed and challenged the interpretations of the discovered patterns using existing theories from the general merger and change management literature, health care restructuring literature and institutional and neo-institutional theories.

Although the embedded case study design is the more extensive variant of a single case design, it was chosen because it provides operational details not allowed by a solely holistic design on the hospital level. Indeed, this approach also generated key insights at the clinical department level, which among many things revealed critical factors that may explain the production of functional outcomes unpredicted by the literature. Moreover, leading scholars argue that studies that try to link process to outcomes is stronger because such studies reduce the complexity of the study design and avoid the danger of drowning in qualitative data that are difficult to shape in any thematic fashion (McNulty & Ferlie, 2002; Miles, 1979). Guided by this recommendation, the embedded clinical cases of this thesis were selected based on maximum variance in outcomes within the same context (i.e. Division Z within the KUH). This approach aided in linking the critical factors and distinguishable phases in the pre-merger process through the post-merger process to the production of successful and unsuccessful outcomes, which demonstrates the value of the case sampling method used in this study.

The findings of this research result from a single case study (i.e. a merged university hospital in Sweden). Therefore the question of generalization deserves attention. This study is concerned primarily with the case of merger processes in public health care. Care must therefore be taken when transferring the findings and tentative explanations from the context of professionalized, public service settings to other contexts, such as private industrial settings.

In recognition that merger processes have no clear beginning and no clear end, it is clear that the findings of this thesis may be limited to the initial post-merger period of a radical change initiative. The post-merger period reported in this thesis covers to a large extent only the first three years. Because merger studies in health care generally have assessed outcome effects within one to three years after hospital consolidation, researchers argue that these studies are at best measuring the *short-term effects* of hospital consolidation. However, integration status was reported to be status quo when validating data six years post-merger (in the year 2010). Hence, this study indicates that the functional and dysfunctional outcomes may actually reflect *long-term effects* of a university hospital merger.

7 CONCLUSIONS

7.1 COMPETING LOGICS IN HOSPITAL MERGERS

This thesis clearly shows that a hospital merger is a process involving a complex interplay of internal and external factors as well as actors in which the hospital management finds it difficult to predict and pro-actively handle relevant issues and conflicts (Jemison & Sitkin, 1986; Greenwood et al., 1994). In particular, hospital management may not appreciate sufficiently the intra- and inter-organizational dynamics inherent in the process such as the professionals' effective use of the media and the political opposition's efforts to further their own agendas in government (McNulty & Ferlie, 2002). Hence this study supports the process school's criticism of the normative strategy school whose proponents assume that management, in advance, can discover and handle relevant strategic and organizational differences (e.g. Greenwood et al., 1994; Jemison & Sitkin, 1986; McNulty & Ferlie, 2002). In agreement with the process school perspective, this study clearly shows that there are several in-built impediments in the merger process itself that obscure its complexity (e.g. the risk of managerial hubris), which makes it difficult for management to plan and carry out smooth post-merger integration.

Additionally, this study shows, in agreement with the previous merger literature, that management at all levels is important for the development and outcome of the merger process (Schriber, 2006). The prescription from the normative literature on successful change management is that management should adopt a linear, planned, top-down approach in radical change (Hammer & Champy, 1993; Kotter, 1996). Researchers who take this point of view typically attribute successful outcomes to the skills and abilities of a "strong individual leadership" (Ibid.). However, the conclusions of this study do not agree with this finding. Although a planned, top-down approach prescribed by classic functional theorists was followed by the management both at the hospital level (Study II) and at the clinical level (see Department X in Study III), that straightforward, top-down approach based on "strong individual leadership" contributed strongly to the unexpected and unintended results (i.e. the unsuccessful outcome). Instead of following a top-down, linear path, the process followed a non-linear, unpredictable and uncontrolled path. The findings of this study suggest that an incremental, emergent, bottom-up approach seems to be a better post-merger management strategy (see Department Y in Study III), as confirmed by other merger studies of professional organizations (Empson, 2000, 2001; Kavanagh & Ashkanasy, 2006.).

One explanation of why an incremental, emergent, bottom-up approach works better for professional organizations is, as mentioned, that management has limited control over the critical knowledge-intensive activities (Birkinshaw et al., 2000) because they are performed by autonomous experts who tend to rely on their own judgement and expertise (Löwendahl, 2005). It has been shown there is a high risk that such professionals will leave an organization when changes are implemented by a top-down approach, taking their knowledge with them (Graebner, 2004; Greenwood et al., 1994). The initiative for change is assumed to depend upon the trust and the willingness of individual autonomous experts who, to great extent, control the integration process (Empson, 2000; Montgomery, 2001). There is clear evidence in both Study II and Study III that the professionals take a significant role in the early merger stages (see also Fulop et al., 2002, 2005). Several studies have also shown that since physicians as a profession

exercise power and successfully require autonomy, a planned, top-down approach is less successful and less workable in health care (McNulty & Ferlie, 2002, 2004).

According to the OB-school literature, the concept of "horizontal" cultural differences between merging organizations has long been pointed out as the main post-merger challenge and the main explanation of merger failures (see Section 2.3.4). Despite the Director's focus on handling the horizontal culture (Study II) conflicts predicted by the OB-school, this thesis shows that the primary challenge for management, both at the hospital level (Study II) and at the clinical department level (Study III), is dealing with the "vertical" difference and the "institutional competition" between managerialism and professionalism. As this study mainly covers the first three years post-merger, the challenge from the horizontal tension may of course occur at later stages following the initial "vertical conflict" stages.

The finding that vertical institutional conflict is a key driver of merger processes, and probably the main explanation of observed outcomes, is fairly consistent with previous research on hospital mergers (see Section 2.2). This literature typically points to the critical role medical professionals have in such mergers. Overall, researchers agree that clinical integration is a highly complex endeavour that takes time to complete. Again, the challenge is to build trust, to obtain professional buy-in and to deal with the resistance from the professionals (Bazzoli et al., 2004). However, there are very few studies that explicitly cite the vertical competition between managerialism and professionalism as the most important explanatory factor in the development and outcome of hospital mergers. The two-sided vertical conflict between managerialism and professionalism is often explained as either the result of failed leadership or of the professionals' resistance that impedes the pace of integration (Fulop et al., 2002, 2005). Although this study revealed that the obstruction by the professionals impeded clinical integration, many traditional merger studies on hospital mergers have continued to argue that horizontal tensions, clashes and other hindering factors between the merging organizations are the main reasons behind hospital merger failures. In similar way, the results from studies of university hospital mergers in the US are somewhat patchy as they place the horizontal tension in the centre (Kastor, 2003; Cohen & Jennings, 2005), at the same time as they report the importance of the conflict between economic, medical and academic logics that obstruct integration (Kastor, 2003).

7.2 IMPLICATIONS FOR THEORY

In stark contrast to existing merger literature, the results of this thesis clearly point to the "vertical conflict" of competing institutional logics (i.e. managerialism vs. professionalism) rather than to the "horizontal conflict" resulting from different organizational cultures as the main post-merger challenge, both at the hospital and clinical department levels. Kitchener (2002), grounding his reasoning on studies of university hospital mergers in the US, particularly one university hospital merger, describes how managers seek legitimacy by making the merger indisputable. The findings of this study agree with Kitchener's observations. His explanatory model identifies phases in the pre- and post-merger processes that have similarities with the observations in this study.

As the starting point, Kitchener uses the notion of conformance to myths (Meyer & Rowan, 1977) to explain the merger phenomenon in health care. Meyer and Rowan (1977: 344) argue that executives within highly institutionalized fields adopt innovations when (and because) they

constitute “manifestations of powerful institutional rules which function as highly rationalized myths that are binding”. This power of normative compulsion ensures that certain practices, as soon as they have been acknowledged, are adopted widely and uncritically not so much to execute tasks more efficiently but to gain legitimacy and cultural support (DiMaggio & Powell, 1983).

Political sociologists such as Brint and Karabel (1991: 355) argue that organizational analysts lack the theoretical tools with which to explain the antecedents of institutionalized myths and the ways in which they are established as social facts within “arenas of power relations”. Previous accounts tend to employ notions such as fashion cycles (Abrahamson, 1991; Staw & Epstein, 2000) that ignore the fact that stakeholders drive these interests.

Therefore Kitchener (2002) integrates selected concepts from political science and social movement theory to extend the capacity of institutional theory to explain organizational change in professional fields. His integrated model addresses (a) the antecedents, (b) the processes and (c) the implications of institutional change processes that involve the uncritical adoption of managerial innovations in professional fields.

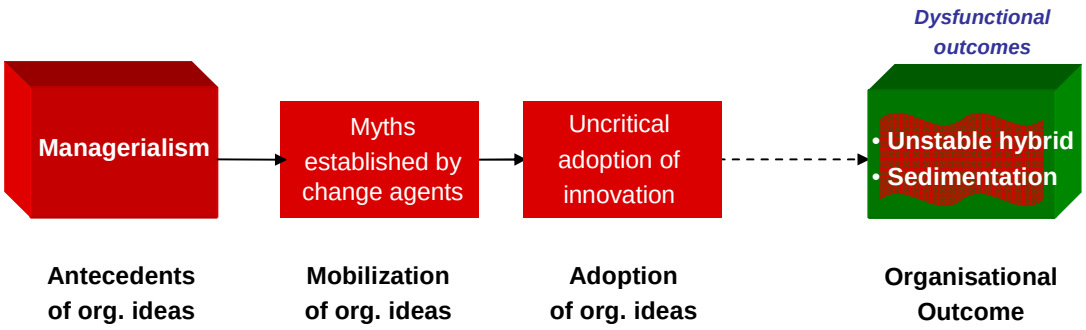

Figure 2: *Kitchener’s (2002) conceptual model for managerial innovations in professional fields*

The final part of Kitchener’s model is especially intriguing in relation to this study. In terms of predicted outcomes, the model suggests that the intended outcomes of managerial innovations such as mergers are unlikely to appear when they are “sedimented” upon the enduring features of professionalism. Cooper et al. (1996) show how the adoption of managerial innovations may not produce the intended outcomes within highly institutionalized fields in their exploration of the emergence of hybrid organizational forms that comprise “sedimented” structures and logics. This geological metaphor is used to describe the unstable organizational forms that emerge when managerial innovations such as mergers are imposed upon the institutional logic and deep structures of professionalism.

7.2.1 An attempt to formulate a theoretical contribution

Kitchener's (2002) model of "managerial myths in professional fields" provides a useful starting point for understanding why dysfunctional organizational outcomes are likely when managerial innovations are uncritically "sedimented" upon the deep structures of professionalism (Cooper et al., 1996). However, Kitchener' (2002) model has not the capacity to fully explain the key findings of this study. First, the initial phase of the model referring to the antecedents does not explain why an organizational innovation idea (e.g. a merger) may also originate from professionalism (i.e. the opposite institutional logic of managerialism). As a consequence, the mobilization phase does not account for the possibility that change agents, who represent competing institutional logics, may initiate a merger by their co-operative acts. Finally and perhaps most importantly, the third phase of the model does not acknowledge the possibility that *functional outcomes* may actually arise even when "executives jump on bandwagons to adopt certain myths uncritically" (Kitchener, 2002: 392). The empirical results of this study fit better with a development of the Kitchener model in the following way.

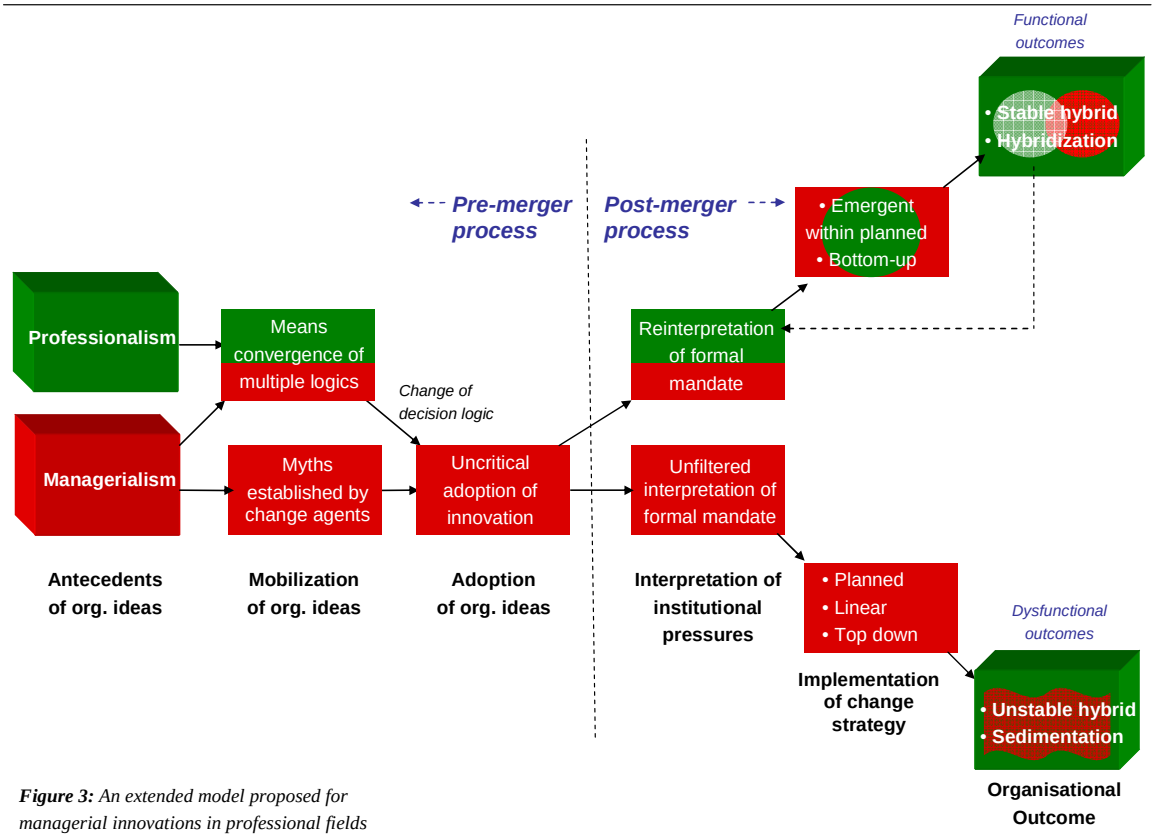

Figure 3: *An extended model proposed for managerial innovations in professional fields*

The first phase of the organizational innovation – antecedents of the idea – includes both the logics of a professional organization, "professionalism" and "managerialism" as possible bases of organizational legitimacy. The second phase – mobilization of the idea – depicts the possibility of mobilizing support for an organizational idea through means convergence (i.e. the competing logics are re-coupled and multiple stakeholders are united). Towards the right, the third phase – adoption of organizational idea – depicts the uncritical adoption of the merger idea, which in our case was the effect of an unexpected change of decision logic (triggered by a critical incident).

This study provides detailed data on the post-merger integration processes at two organizational levels: the hospital and the clinical department levels, that allows the link between the pre-merger process and organizational outcomes to be explored more thoroughly than in Kitchener's (2002) original model, which largely addresses the pre-merger phases. By extending the model with additional phases in the post-merger process, the new model reveals the conditions and formula for a more prosperous alternative to dysfunctional outcomes: the scenario of functional merger outcomes.

The first new element is attributed to the critical role management at all organizational levels plays in its "interpretation of institutional pressures" (manifested by the formal mandate) and the change context (e.g. manifested by professionalism). Two possible options emerge from the empirical analysis: 1) an unfiltered interpretation of the formal mandate stemming from top-down pressures on the legitimacy bases of a pure managerial logic; and 2) a re-interpretation of the formal mandate to address the competing institutional logics of professionalism and managerialism.

Moving further to the right, "implementation of change strategy" addresses the different change approaches observed in Study II and Study III. The top-down, planned approach demonstrated by the top management (see Study II) and the clinical manager at Department X (see Study III) follows the literature's classic management prescription originating in the strategy school (see Section 2.3.3). The bottom-up, emergent approach demonstrated by the clinical managers at Department Y (see Study III) is consistent with the literature's prescriptions for professional organizations originating in the process school (see Section 2.3.5). However, a closer analysis reveals that the management in Department Y (Study III) used an emergent change strategy *within* planned boundaries (set by top management), which reflects a more recent research stream that combines the emergent with the planned approach to change (e.g. Bamford & Forrester, 2003; Bartunek, 2003).

In Kitchener's (2002) explanation of why mergers often lead to dysfunctional outcomes, he states that an "uncritical adoption" of an organizational innovation is likely to achieve only a "sedimented layer" of managerialism that does not penetrate the deep structures of professionalism.

An important empirical contribution of this study is therefore the observation that functional outcomes were unexpectedly produced by one of the clinical cases. Functional outcomes were manifested through a successful clinical integration, which seemingly was a result of an 1) interpretation of institutional pressures, 2) a change strategy and a 3) management system designed to fit both the logics of *professionalism* and *managerialism*. This "hybrid approach to change" allowed a *re-coupling* of competing logics in a shared hybrid arena (at clinical department level) as well as a classic *de-coupling* of them by dividing managerial responsibilities between the professional and administrative domains (typical for political organizations). In more practical terms, one formal manager managed issues "up-wards" to satisfy the needs of the formal agenda and one informal manager managed issues "down-wards" to meet the demands of the professionals.

7.2.2 Practical implication

It is evident from the findings of this and previous studies that competing logics easily cause high emotional and professional costs for "hybrids individuals" i.e. physician managers (Montgomery, 2001), which may impede their important task of balancing competing logics of professionalism and managerialism. Although Cooper et al. (1996) claim that hybrids are schizoid and unstable organizational forms, this study shows that the design of a stable enduring hybrid management systems is still possible (McNulty & Ferlie, 2002, 2004) and may *de facto* have better prospects for success than hybrid positions (i.e. physician managers). Such hybrid systems may even increase organizational legitimacy, when attempts to achieve radical change are made in organizations embedded in "deep structures" of profession

7.2.3 Future research

This alternative model of establishing managerial ideas in highly institutionalized fields is consistent with neo-institutional theories on radical change that predict that convergent change rather than a radical change is more likely to occur in professionalized fields when there is a battle between the two competing logics of managerialism and professionalism (Greenwood et al., 2004; McNulty & Ferlie, 2002, 2004). However, assuming there will be further limitations to organizational reforms designed to achieve radical change due to the enduring legitimacy bases of professionalism, future researchers and policy-makers are encouraged to take a renewed interest in "hybridization" as a possible alternative to movements from one "pure" archetype to another. Hybrid arrangements encompassing competing logics appear to pose different questions. Among these questions are governance questions about the required regulations and governance methods, organizational identity/culture questions about making sense of conflicting demands and coping with them, and the needed change processes for balancing competing institutional logics. The theories of radical change seem to be of less relevance in answering such research questions. Hybridization, as McNulty and Ferlie (2004) argue, may even show the way into a post-NPM era.

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Stockholm, 31 January 2011

Soki Choi

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10 ENDNOTES

[i] In 1997, Mölndal, Östra, and Sahlgrenska hospitals were merged into Sahlgrenska University Hospital. Note that only one hospital (i.e. Sahlgrenska hospital) was a university hospital *pre-merger*. Hence, this merger cannot be considered "a merger of equals" as opposed to the Karolinska University Hospital and Skåne University Hospital merger.

[ii] M&As refer to listed companies in the private industry, which is inapplicable for health care organizations in public settings (such as in this study).

[iii] Recently, researchers in this field (e.g. Golbe & Whit, 1988) have sought to identify potential causes of merger waves, which are said to be crucial in the forecasting of merger activity. While the general notion that mergers occur in waves is practically undisputed, there is no clear consensus on how to model and identify the precise timing of distinct merger waves.

[iv] Economic history has pointed to five different merger waves in the business world. The merger wave of the 1980s and early 1990s differed substantially from that of the previous great boom of the 1960s and early 1970s, not only in terms of increased scale and geographical spread but also in terms of merger type (Ibid.). In the merger wave of the 1960s and early 1970s, most combinations were of the conglomerate type. In contrast, most combinations during the merger wave of the 1990s and 2000s have been of the horizontal or related type (Cartwright & Cooper, 1992). Many of these mergers have also been cross-border, which has resulted in more research on global mergers, especially those taking place in East Asia and Europe (Søderberg &. Vaara,, 2003.).

[v] Their synthesiszed review includes 101 articles, working papers, monographs, and books. They also claim that it is the first review to bring together both quantitative and qualitative research to assess organizational change in health care.

[vi] "Strategic fit" is commonly understood as the degree to which the merging firms complement or augment one another's operations and strategies (see also Datta, 1991). Differences between merging companies are generally framed in terms of complementarities, whereas similarities are framed in terms of synergies.

[vii]" Organizational/cultural fit" refers to differences between the administrative and cultural practice of merging firms as well as personnel characteristics (see e.g. Datta, 1991; Sales & Mirvis, 1984). According to this "horizontal fit" perspective, the most problematic situations are those where the values and beliefs are contradictory.

[viii] I.e. Managers' tendency to be overenthusiastic and overconfident about merger outcomes in the merger planning stage.

[ix] By outcome, this thesis refers to intermediate organizational outcomes (rather than the final outcome characteristic of biomedical research). See Study III for detailed information on our use of 'outcome'.

x In Study III, this aspect was handled by collecting interviews from both the managers (change agents) and the staff (change recipients).

[xi] Because a "conventional approach to content analysis" was largely used, it will only be summarized in this section (see e.g. Hsieh & Shannon, 2002 for more details). A challenge to this approach is that it can easily be confused with other methods such as grounded theory. However, although grounded theory may seem to share a similar initial analytical approach, it goes beyond content analysis to develop theory.

[xii] Driven by a political agenda, large and quick cost savings expected from the merger were based on SCC's roughly calculated cost savings needed to balance the budget by the next political election (rather than by detailed calculations of potential synergies).

[xiii] Calculated as €20 million in achieved savings (including surplus) in year 2005, divided by €1000 million in annual turnover.