Hospital Mergers and Acquisitions: A New Catalyst for Examining Organizational Ethics

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Only recently has attention and emphasis been placed on organizational ethics in health care communities. The changing face of health care, including elements such as mergers and acquisitions, are forcing organziations to define clearly the ethical standards upon which the organization makes decisions and policies. The odds of successful integration in a health care merger situation are enhanced when relationships are built on trust and when guidelines for ethical behavior are well-enunciated and adopted.

Institutional and individual health care providers historically have emphasized a wide range of issues related to clinical ethics, but have failed to pay comparable attention to organizational ethics. The development of ethics manuals, ethics audits, policies governing conflicts of interest, and even the designation of individuals responsible for compliance with the corporation's ethical standards have had a far longer history in the general business community than in the health care sector. Only recently has the Joint Commission on Accreditation of Healthcare Organizations developed standards pertaining to "organization ethics" and mandated that hospitals operate according to a code of ethical behavior (Joint Commission on Accreditation of Healthcare Organizations 1996).

Why has the health care industry paid little attention to organizational ethics? Part of the explanation lies in its largely eleemosynary tradition. Medicine and allied health professions have a charitable heritage that carries an implicit commitment to caring for others. Because this value has been central to these professions, the organizations through which they provide services have been less cognizant of the need to make formal examination of additional values affecting institutional behavior. Moreover, when organizational values are specified, there may be considerable distance between expressions of intent and operational reality.

Religious-sponsored health care institutions have demonstrated greater initiative in examining and addressing issues affected by organizational ethics. And yet today, regardless of sponsorship, every hospital and health care system has an additional incentive to focus on these issues, namely the remarkable increase in hospital mergers and acquisitions.

Ethics Challenges in Mergers and Acquisitions

The significant decline in length of stay and hospital admissions, partially stimulated by the growing influence of managed care, has produced record low occupancy rates (HCIA and Delloitte & Touche 1995). As a result, many parts of the country have witnessed a large increase in the number of excess beds, and the surplus is projected to be even greater in major metropolitan markets such as Dallas/Fort Worth, Minneapolis/St. Paul, Chicago, St. Louis, Los Angeles, San Francisco, and Philadelphia by the year 2000 (*Business and Health Magazine* 1995). This development,

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combined with the unprecedented pressure on institutions to reduce costs, has encouraged standalone hospitals to re-evaluate their long-term financial viability.

Propelled by these circumstances, both not-for-profit and investor-owned health care systems have been purchasing hospitals that fit their strategic objectives. Such arrangements, when added to the dramatic rise in other types of affiliations designed to leverage group purchasing contracts, mean that fewer hospitals are operating today without some linkage with similar institutions. One report indicated that a record 735 hospitals were involved in mergers and acquisitions in 1995 (Lutz 1995); transactions of all types, including medical groups, long-term care facilities, home health agencies, HMOs, etc., were up thirty-four percent in the first quarter of 1996 over the previous quarter (Lutz 1996).

Too often, however, the conventional due diligence process preceding mergers and acquisitions concentrates almost exclusively on financial, legal, and regulatory matters. Disregarded, or inadequately considered, are differences in corporate cultures, including organizational vision and values. The possibility of serious future conflict is likely unless existing and potential incompatibilities are thoroughly evaluated. In fact, some proposed consolidations are never consummated because such problems are ignored or underestimated. One health system trustee itemized more than a dozen challenges and sources of conflict in a potential merger, including different organizational histories and roots, board role and composition, attachment to ethnic or religious groups, opposition from medical constituencies, and selection of CEO and board chair (Canning 1995).

The situation is exacerbated by the public's generally negative perception of this nation's hospitals. While generic attributes could be identified to describe a typical hospital, other characteristics might well be unflattering. For example, it would not be difficult to find critics who view hospitals as bureaucratic, costly, impersonal, and competitive. Almost without exception, proponents of mergers vow that bureaucracy and costs will be reduced, patient services will be enhanced, and integration and collaboration will serve the community's best interests.

Unfortunately, although inflated or unrealistic expectations are not consciously promoted by merger advocates, there is a tendency to exaggerate the benefits and minimize the liabilities. In their zeal to alleviate the reservations of key stakeholders, supporters may underestimate both internal and external obstacles. The editor of the *New England Journal of Medicine* has suggested that the principal beneficiaries of "the merger-acquisition frenzy" are corporate executives, stockholders, lawyers who broker consolidations, and health care consultants. He seriously questioned whether the majority of this activity actually adds value to our health care system (Kassirer 1996).

Another observer portrays a darker side, noting:

> Overnight, merged hospitals lose their identity. Name, logos and stationery become scrap. From boards of directors on down to unit supervisors, the leadership changes. Deeply rooted traditions and policies are cast aside. Clinical departments consolidate, and whole building complexes shut down. Longtime working relationships are broken up. Employees who survive layoffs work double time, performing normal duties while trying to redesign their jobs (Holoweiko 1995).

However, a merger also provides a unique opportunity to transform the newly created organization in positive ways, changing its direction and expanding its horizons. One of many keys to finding a successful formula is to face reality as it is, not the way we wish it were.

Suggested Approach

The apprehension and uncertainty associated with a merger produce anxiety around issues of institutional control and direction. The importance of confronting these issues explicitly becomes critical when an affiliation involves hospi-

tals, which have competed against each other for decades. Maximizing the level of trust must be high priority. The following principles have been proposed to facilitate building trust in merger situations.

1. Start from the top. Hospital officials should involve civic leaders in their plans for expanding or otherwise changing services. Those leaders likely have the confidence of the community at large.
2. *Let the community feel a sense of ownership.* Allow members of the community to participate in assessing local health needs and choosing how to address them.
3. *Share information.* Explain the hospitals' intentions to community representatives and establish a dialogue to avoid suspicion.
4. *Work with all key players.* Bring together all the groups with information on and interests in key issues. This allows the community to build on existing resources and prevents anyone who could potentially undermine the program from feeling left out.
5. *Be inclusive.* Identify all the people in the community who might have interest in the new project. One hospital invited a group of about 150 stakeholders, including new mothers, business people, clergy, teenagers, and senior citizens, to participate in forming its plan.
6. *Find common ground.* Ask the community representatives to identify what they have in common through a discussion of health care and healthy communities.
7. *Make meetings friendly and comfortable for the community.* Don't hold all the meetings at the hospital, but move them to various sites within the community. Avoid jargon in discussing the hospital's plans. Consider using a trained facilitator who will encourage group discussion.
8. *Value people over timetables.* Give the community time to grow comfortable with change before taking drastic steps that may be considered by some to be dramatic or drastic.
9. *Focus on the process as much as the outcome.* Finding a process for creating trust among community members is a major accomplishment. It is this process that leads to a better outcome (Strenger 1996).

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The integration of ethics into health care organization mergers also includes attention to other basic elements of relationship building, including integrity and confidentiality. If either of these are violated, the ability to sustain a genuinely productive partnership could be irreversibly compromised.

At the outset of negotiations, real and imagined differences in organizational culture must be evaluated. There may be dissimilar philosophies pertaining to corporate values, governance, management style, physician roles, community orientation, outsourcing, downsizing, financial versus nonfinancial priorities, and a host of other issues. Ignoring or minimizing substantive differences and failing to reconcile them will imperil the long term viability of the newly created organization. Depending upon the number of facilities involved, consolidation of clinical services is sometimes compulsary. Dissension over these kinds of developments cannot be avoided, but an institution's code of ethical behavior should indicate how conflict resolution is addressed.

Inevitably, there will be occasions when major disputes before or after a merger may jeopardize the consolidation. In such instances, the parties may benefit by retaining an impartial facilitator or mediator to help the key stakeholders resolve their differences. The formal goal should be the delineation of practical and ethical steps to

overcome obstacles to genuine collaboration.

Conclusion

If not identified and addressed early, differences in expectations will severely compromise the ability of constituency leaders to create the level of mutual trust, respect and confidence essential to an effective integration process. Few organizations are likely to engage intentionally in unethical practice. However, the absence of clearly defined ethical standards may imply that the leadership places little or no priority on supporting and promoting ethical behavior. The odds of successful integration are greatly enhanced when organizational relationships are built on trust, and when guidelines for ethical behavior are well-enunciated and adopted.

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