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Is there room for whistle-blowing in hospital mergers?

The feedback dimension of the policy process

A paper presented at the IRSPM conference in Rome, April 11-13, 2012

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Abstract

Whistle-blowing can serve as a powerful mechanism helping policy-makers and other stakeholders recognize ethical misconduct and other types of wrongdoing in autonomous public agencies. This mechanism is of particular importance in major public sector reforms, such as agency mergers, when it may be difficult to secure continuity in the quality of organizational processes. Yet, we know little of what opportunities for whistle-blowing characterize these reforms, as the feedback dimension of the policy process has been relatively neglected. This paper explores what opportunities for whistle-blowing are provided to physicians in mergers of autonomous public hospitals. In the health care sector, the professional ethics of physicians may provide strong incentives for whistle-blowing, aiming to preserve patient interest. A survey was distributed to 663 physicians and 12 managers at a Swedish hospital, which two years earlier had undergone a merger. Today, this is one of the largest hospitals in Europe. The response rate was 54 per cent and 7 out of 12 managers. Results reveal that managers and physicians had the opposite perceptions of merger outcome – 80 per cent of physicians considered it a failure, whereas most (5 out of 6 responding) managers considered it successful. Among physicians, 64 per cent stated that employees could not express objections to the hospital management without risking sanctions, whereas most managers (5 out of 7) believed that they could. Finally, responses reveal that physicians (93 per cent) and managers (7 out of 7) agree that there is not a working dialogue between professionals and policy-makers. In this specific merger, opportunities for whistle-blowing were limited. Some possible explanations are outlined. The lack of transparency is a democratic problem, aggravated by the major stakes in hospital mergers.

Key words

Mergers, hospitals, health care management, policy process, whistle-blowing, public management

Is there room for whistle-blowing in hospital mergers?

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A number of scandals in business as well as the public administration have lined the beginning of the 21st century and many ask themselves how misconduct and unethical behavior can be prevented. In particular, at times of rapid organizational changes and major public reforms, audit functions may not always be able to recognize misconduct, at least not in a timely manner. Therefore, whistle-blowing by employees may serve as a complement to formal performance indicators and audit reports, helping various stakeholders to notice fraud, ethical misconduct and other types of wrongdoing. However, this requires that opportunities for whistle-blowing are actually provided.

We know rather little of what opportunities for whistle-blowing are associated with public sector reform. One reason may be the predominant focus on governance issues in the top-down dimension of the policy process (deLeon and deLeon 2002). Less attention is typically directed to the feedback dimension of the policy process, including models for employee influence (e.g. Sabatier 1986). The policy process includes aspects relating to how public policy is developed, communicated, implemented, and evaluated. Evaluation is typically understood as a matter of formal performance indicators. Yet, these indicators are quite narrow and limited and, not least, they may be designed according to political or managerial considerations. Whistle-blowing provides with another kind of feedback, which is less easily to predict and plan for. This feedback will place those in charge, be it policy-makers of managers, at a dilemma, as they consider whether to react on the information or not. A study among members of an audit committee revealed that the higher the risk for their personal reputation, the lower the propensity for them to react on the alarm. Whistle-blowing from employees may also put policy-makers at unease, as it forced them to decide whether to react or not.

In hospital mergers, stakes are high. These reforms are major investments in time, money and patient risk and failure rates are high (e.g. Bazzoli, LoSasso, Arnould, Shalowitz, 2002; Bazzoli, Dynan, Burns, Yap, 2004; Kjekshus and Hagen, 2007). This makes whistle-blowing a useful mechanism to avoid misconduct. With autonomous public hospitals, policy-makers are reliant on correct information from the agency management. However, these managers have incentives to communicate progress, regardless of the actual outcome, in order to avoid blame. Blame-avoidance is common among autonomous public agencies (Weaver 1986; Kelman 2005; Hood 2002, 2007) and issues of blaming have been noted also in mergers of central agencies (Bringselius 2012), as well as hospital mergers (Choi, Holmberg, Löwstedt, Brommels 2011). Professionals, on the other hand, based on their professional ethics, may have the opposite incentives and wish to point out problems, referring to this as whistle-blowing. This indicates that the two groups may give different accounts for merger outcome, regardless what the actual outcome is.

What opportunities for whistle-blowing are associated with hospital mergers and do managers and physicians give similar accounts for the outcome of the merger? This paper compares how managers and physicians perceive physicians' whistle-blowing opportunities following a merger and how they account for the outcome of the merger. It draws on a combination of the M&A literature and the health care management literature. Results from a survey at Southern Sweden University Hospital (in Swedish *Skånes universitetssjukhus*), which underwent a merger January 2010, are reported. The study reveals that there are substantial differences between how managers and physicians perceive and perceive/account for merger outcome. There are also substantial differences

in how the two groups perceive employees' possibilities to express criticism without risking sanctions from the hospital management. Neither physicians, nor managers, experience that there is a working dialogue between professionals and policy makers. Possible explanations are discussed and it is concluded that because personal agendas may influence the information strategies adopted by managers, policy makers and physicians. From a democratic perspective, the neglect towards physicians' feedback is problematic, since this means that it cannot be ensured that citizens are provided with correct, or at least nuanced, information on how the public administration performs. Therefore, they will not be able to hold the responsible policy-makers accountable, for example in public elections. Further research in this area is encouraged.

The paper is organized as follows. First the literature on whistle-blowing and the policy process is introduced. After this, a section on hospital mergers follows. The research design is then depicted and the case study context is introduced. In the next section, findings are reported. A discussion follows. Finally, there is a brief section with conclusions.

Whistle-blowing and the policy process

Whistle-blowers are defined by Near and Miceli (1985:4) as 'organization members (including former members and job applicants) who disclose illegal, immoral, or illegitimate practices (including omissions) under the control of their employers, to persons or organizations who may be able to effect action'. This definition includes wrongdoing, which is not criminal, but violates some kind of norms, typically what Warren (2003) refers to as *hypernorms*. This is 'globally held beliefs and values' which 'encompass basic principles needed for the development and survival of essential background institutions in societies (Warren 2003:628). Referring to societal norms or organizational norms to justify whistle-blowing is usually not always sufficient, since these norms may clash with hypernorms, although there are exceptions.

The literature on whistle-blowing has traditionally covered one of two areas, the first focusing on why employees engage in wrongdoing and the second focusing on why employees engage in whistle-blowing (Near and Miceli 2011). Less attention has been devoted to the interface between these areas – the organizational dynamics in which misconduct, as well as whistle-blowing, is fostered. This is also suggested by Near and Micel (2011) as an interesting avenue for future research on whistle-blowing. This line of research can be conducted within the scope of culture studies, but it can also be conducted with a focus on the policy process and the dialogue between policy-makers, managers and employees. Whistle-blowing takes place in what we chose to refer to as 'the feedback dimension of the policy process'.

The policy process is typically understood as the process through which public policy is developed, communicated and implemented. However, this also involves evaluation and policy revision. This is the feedback dimension. In a review of the policy implementation literature, deLeon and deLeon (2002) conclude that one of the problems with this literature is its 'basic reliance on a command orientation', including the top-down perspective, focused on governance issues. They suggest that a bottom-up approach would be more interesting, and point out that this perspective also allows us to capture important democratic aspects. Not least, it is important to understand if policy-makers, managers and employees account to the public in the same way, as concerns policy outcome. Policy-makers and citizens will need correct information from the public agency for several reasons.

- The citizens will need this information in order to be able to hold responsible policy-makers accountable in public elections;
- The citizens will need this information to be able to choose health care provider (when provided on a market);
- Policy-makers will need this information to be able to adjust public policy, if needed;

- Policy-makers will need this information to hold managers accountable and evaluate their performance.

There are also other stakeholders who will need accurate information on merger process, for example suppliers and patient organizations. Because policy makers need to have correct information, there has been a growing interest in 'evidence-based policy making', signifying a strive towards a more informed decision process (e.g. Sanderson 2002; Pawson & Tilley 1997; Davies et al 1993).

It is worth noting that the bottom-up approach must not necessarily focus on employee *influence*, but it can also focus on opportunities for employees to conduct whistle-blowing, or at least present some kind of feedback. In the case of feedback, policy-makers and managers can choose whether they wish to react on this or not. This differs from influence, which intervened in the decision making process. Employee feedback can be requested on a regular basis, as one performance indicator among many, and consulted by policy-makers in their policy evaluations. An example of this is the yearly employee attitude surveys sometimes conducted at public agencies. Otherwise, formal performance indicators can be manipulated according to political or personal agendas. Whistle-blowing is the performance indicated which it is least possible to formalize, plan or design.

Physicians' attempts at whistle-blowing in the health care sector is made difficult by the common notion of physicians being difficult to manage. Alerts are easily waved aside. In particular, with the New Public Management and its emphasis on professional managers, the classic conflict between managerialism and professionalism (Ackroyd, Kirkpatrick & Walker, 2007) has shifted to the advantage of the former. Yet, physicians have a high degree of autonomy in their every-day work – a work which managers typically do not have access to. This also gives them access to extensive information. The professional ethics of physicians also motivates them to safeguard the interests of the patient (Amundsen 1978; Freidson 2001; Wynia, Latham, Kao, Berg and Emanuel 1999). Managers, on the other hand, have a wider responsibility, managing operations so that public policies are implemented as intended and within the scope of the available budget. This includes balancing the values of democracy, efficiency and legality. However, studies (Moynihan and Pandey 2010) suggest that managers also experience a pressure to signal decision power, modernity, competence and success.

Whereas strong professions such as physicians occasionally are pointed out as problematic, as managers attempt to implement changes, it must also be emphasized that the competence and the professional ethics of this group may be an asset in change processes. Not least, attempts at whistle-blowing ought not be less welcome when presented by this knowledgeable group, than it is in any other context. As Hirschman (1970) noted, open criticism may be more loyal to the organization than the choice to leave (exit).

Hospital mergers

Hospital mergers have become increasingly common in the Western world over the past decades. A driver is wishes to cut public spending by benefiting from synergies of scale. They encompass major risks, in terms of quality of care and work health, but also major financial investments. Yet, several studies (e.g. Bazzoli, LoSasso, Arnould, Shalowitz, 2002; Fulop, Protopsaltis, King, Allen, Hutchings, Normand, 2002; Bazzoli, Dynan, Burns, Yap, 2004; Kjekshus and Hagen, 2007) point at recurring failure to achieve the expected synergies in these mergers. The outcome is equally poor in mergers and acquisitions (M&A) in other sectors, as indicated in the more general body of research in this area (e.g. Hubbard, 1999; Cartwright, 1998).

In the M&A literature, the human aspects have been pointed out as a key reason for the recurring failures. M&A, it is noted, are typically characterized by employee resistance, distrust and reduced work satisfaction, sometimes referred to as 'the merger syndrome' (Marks and Mirvis 1985). This body of literature therefore addresses a wide range of sociocultural and human resources issues (e.g. Teerikangas and Very 2006; Empson 2001; Chun and Davies 2010; Bartels, Douwes, Jong

and Pruyn 2006; Millward and Kyriakidou 2003; Birkinshaw, Bresman and Håkanson 2000; Densten 2008). A number of recent contributions on ethics and perceived justice (e.g. Ellis, Reus and Lamont 2009; Meyer 2001; Lipponen, Olkkonen and Moilanen 2004; Klendauer and Deller 2009) suggest that the managerial ethics may be one reason why employees often react with distrust in M&A.

Research design

We have chosen to conduct a single-case study of a hospital merger, namely the merger of the two university hospitals in Malmö and Lund, two cities in the south of Sweden, circa 20 kilometers apart. January 1, 2010, they formed the new Southern Sweden University Hospital (in Swedish Skånes universitetssjukhus). This is an autonomous public hospital under the Regional Council and one of the largest hospitals in Europe. The merger has been subjected to extensive criticism in the media, primarily by physicians, whereas regional policy-makers and hospital managers have given more positive accounts on the process.

A survey was distributed November 8, 2011. This was two years after the merger. After January 1, 2012, the hospital management would resign due to retirement and for this reason, it was important to distribute the survey no later than towards the end of year 2011. The survey was limited to 12 hospital clinics, all reporting to the general hospital management. Each clinic was lead by a manager and a separate survey was distributed to these managers a few days later. In total 663 physicians received the survey and 355 out of these responded, resulting in a response rate at 54 per cent. We consider this as excellent, in particular since it is a problem that physicians seldom respond to surveys (Cook, Dickinson and Eccles 2009; Cummings, Savitz and Konrad 2001). Out of the 12 managers, 7 responded. Respondents were allowed to be anonymous and the survey was distributed by post.

The survey was designed according to Table 1. Three research questions were formulated, to guide the development of survey questions:

- RQ1: How do physicians and managers of medical clinics perceive merger outcome?
- RQ2: How do physicians and managers of medical clinics perceive employees' opportunities to express criticism without fear of sanctions?
- RQ3: What is the quality of communication in the feedback dimension of the policy process?

RQ1 aimed to understand whether at all physicians considered that there had been a reason to conduct whistle-blowing in the merger, and to compare to managerial perceptions. A gap would also indicate some kind of communication problem. We included one question on the general perception of the outcome of the merger process, and four questions were more specific and focused on quality of care, efficiency, work environment and employee turnover respectively.

RQ2 aimed to understand how physicians and managers perceived opportunities for whistle-blowing in the relation between professionals and hospital management and in the relation between professional and the management of the medical clinic.

RQ3 aimed to understand the quality of the dialogue in the feedback dimension of the policy process, with a special focus on physicians. It focused on both the dialogue between physicians and the hospital management, and the dialogue between physicians and policy-makers.

In total, this design results in nine survey questions. Survey questions 1-5 are rated on a scale ranging from 1-4, where 1 signifies a highly negative outcome and 5 a highly positive outcome. Survey question 5 uses the same scale, but with 1 signifying very little and 5 signifying very much. In survey questions 6-9, a Likert scale ranging from 1-5 is again adopted, and in these cases, 1 signifies that the respondent totally disagrees, whereas 5 signifies that the respondent totally agrees.

Table 1. Research design with survey questions

Research/survey design	
RQ1:	How do physicians and managers of medical clinics perceive merger outcome?
Considerations:	Outcome in general, plus more specifically based on four categories: Quality of care, efficiency, work environment, employee turnover.
Survey question no. 1:*	How do you experience that the merger has functioned more generally at the hospital?
Survey question no. 2:*	How do you experience that the merger has affected care quality at your clinic?
Survey question no. 3:*	How do you experience that the merger has affected efficiency at your clinic?
Survey question no. 4:*	To what degree do you experience that the merger has resulted in the loss of key employees at your clinic?
Survey question no. 5:*	How do you experience that the merger has affected the work environment at your clinic?
RQ2:	How do physicians and managers of medical clinics perceive employees' opportunities to express criticism without fear of sanctions?
Considerations:	Distinguish between sanctions from hospital management and sanctions from managers of clinics.
Survey question no. 6:*	As an employee at SUS, I can be openly critical without risking sanctions (some kind of punishment) from the hospital management.
Survey question no. 7:*	At my medical clinic, employees can be openly critical without risking sanctions (some kind of punishment) from the clinic management.
RQ3:	What is the quality of communication in the feedback dimension of the policy process?
Considerations:	Distinguish between the dialogue between physicians and hospital management and the dialogue between physicians and policy-makers.
Survey question no. 8:*	At SUS, there is a trustful and working dialogue between physicians and the hospital management.
Survey question no. 9:*	At SUS, there is a trustful and working dialogue between physicians and regional policy-makers.

**) Please note that survey question is not equal to the question number in the actual survey, which covers also many other areas.*

SUS = Southern Sweden University Hospital (Skånes universitetssjukhus, Sweden)

Survey results

Survey results are summarized in Table 2. Responses by managers of clinics are stated both as percentages and in absolute numbers. With as few respondents as seven, these would normally not have been converted into percentages, but in this case this facilitates comparisons with responses by physicians, as stated in Table 2.

As regards RQ1, survey questions 1-5 show that there is a large gap in how physicians and managers perceive – or account for - the outcome of the merger process. While 80% of physicians consider the merger a failure and only a few (5%) are positive, 5 out of 6 responding managers consider it success and the last respondent is hesitant. The gap continues in survey questions 2-5, concerning quality of care, efficiency, work environment and employee turnover. Managers are somewhat more negative to the effect of the merger on the provided quality of care.

As regards RQ2, survey questions 6-7 show that 64% of physicians believe that employees risk sanctions by the hospital management in case they are openly critical. The corresponding number relating the management of the medical clinic is 36%. Managers, on the other hand, mainly disagree. On hospital level, 2 out of the 7 managers believe that such sanctions occur, whereas the other 5 managers believe that they do not. On the level of medical clinics, all 7 managers believe that employees can be openly critical. This can be compared to 42% of physicians. There appears to be more room for whistle-blowing by physicians in the relation to the management of medical clinics than in relation to the hospital management.

As regards RQ3, survey questions 8-9 show that 80% of physicians believe that there is not a working dialogue between physicians and hospital management, whereas only 5% believe the opposite. Managers have different views in this matter, with 3 stating that this dialogue is not working, 1 hesitant and 3 stating that this dialogue works fine. Finally, there is an overwhelming agreement among managers and physicians as concerns the dialogue between physicians and policy-makers – 93% of physicians and all 7 managers believe that this dialogue is not working.

Many respondents make highly critical comments in the survey, where opportunities for open comments are provided. Several state that disagreement is not accepted and that the merger process has encompassed serious mismanagement. One respondent (no. 162) explains:

> *"If employees express criticism, they are requested to leave the organization and this is also what a number of colleagues already have done. Catastrophic consequences for the quality of care. Damages are not reported. The previous tradition of reporting problems is gone – now you must keep silent!"*

Table 2. Survey responses from physicians and managers of medical clinics.

Survey question	Group of respondents	Negative/ disagree (1-2)	Hesitant/ equal (3)	Positive/ agree (4-5)	Respon-dents	Missing response
1	*How do you in geneal experience the outcome of the merger?*					
	Physicians	80,2	14,9	4,9	328	27
	Managers of clinics	0,0	16,7 (1)	83,3 (5)	6	1
2	*How do you experience that the merger has affected the quality of care at your clinic?*					
	Physicians	60,5	36,5	3,0	342	13
	Managers of clinics	28,6 (2)	28,6 (2)	42,3 (3)	7	0
3	*How do you experience that the merger has affected efficiency at your clinic?*					
	Physicians	62,5	32,4	5,0	339	16
	Managers of clinics	0,0	28,6 (2)	71,4 (5)	7	0
4	*How do you experience that the merger has affected the work environment at your clinic?*					
	Physicians	72,5	21,3	6,2	342	13
	Managers of clinics	14,3 (1)	42,9 (3)	42,9 (3)	7	0
5	*To what extent do you experience that the merger has resulted in the loss of key employees at your clinic?*					
	Physicians	34,3	20,6	45,2	330	25
	Managers of clinics	85,7 (6)	0,0	14,3 (1)	7	0
6	*As an employee at SUS, I can be openly critical without risking some kind of sanctions (punishment) from the hospital management.*					
	Physicians	64,3	16,3	19,4	294	61
	Managers of clinics	28,9 (2)	0,0	71,4 (5)	7	0
7	*At my medical clinic, employees can be openly critical without risking some kind of sanction (punishment) from the clinic managment.*					
	Physicians	35,9	22,1	42,0	331	24
	Managers of clinics	0,0	0,0	100,0 (7)	7	0
8	*At SUS there is a trustful and working dialogue between physicians and the hospital management.*					
	Physicians	80,6	14,7	4,7	340	15
	Managers of clinics	42,9 (3)	14,3 (1)	42,9 (3)	7	0
9	*At SUS there is a trustful and working dialogue between physicians and regional policy-makers.*					
	Physicians	92,9	5,4	1,8	336	19
	Managers of clinics	100,0 (7)	0,0	0,0	7	0

Discussion

Survey responses reveal that merger outcome is perceived very differently by physicians on the one hand and by managers of clinics on the other hand. This can indicate that one of the two groups has more information than the other group. Managers have access to various performance indicators, but physicians have access to the every-day work, where other effects than those captured by formal performance indicators may be found.

However, accounts may also be understood as rhetoric, reflecting a personal or professional agenda. Accounts by managers may reflect a sense of loyalty to the hospital management and/or to policy makers, who may expect them to portrait the reform this way. They may also wish to respond this way in order to avoid drawing negative attention to their clinic, in particular since several of the managers stated which clinic they represented. It may be considered as a professional tactic by managers in a change process to communicate progress, regardless of how the change process actually enrolls. These models are, however, not adjusted to the public sector, where democratic transparency and public accountability are important aspects (Heinrich, Lynn and Milward 2009; Przeworski, Stokes & Manin 1999). Among physicians, on the other hand, accounts may mirror a more general frustration with the merger process

Whistle-blowing opportunities are limited, according to physicians, but it is again interesting to note that managers disagree. There can be several explanations. For example, managers may not be aware of how physicians perceive the situation, or managers may be aware, but responses may be a matter of rhetoric. Whistle-blowing opportunities are better, but still limited, at the medical clinics.

As concerns the dialogue between physicians and the hospital management, and the dialogue between physicians and policy-makers, physicians appear to be rather isolated in the organization, with very limited opportunities to channel their feedback upwards through the policy process. It appears as if policy-makers have not encouraged feedback or whistle-blowing attempts by physicians, but instead, they have focused only on the dialogue with the hospital management. With autonomous public agencies, this may appear to be a simple solution for policy-makers with limited time to devote to the evaluation of policy implementation. However, avoiding this kind of dialogue is also a way to avoid blame, and point towards the agency management in case of failure, as found in autonomous central agencies (e.g. Weaver 1986; Hood 2002, 2007)).

The limited opportunities for whistle-blowing provided to the professionals in this specific merger is a democratic problem. The lack of transparency leaves citizens with un-nuanced, perhaps even biased, information on the actual outcome of the merger. It also leaves knowledgeable professionals, which the organization is highly reliant upon, in an isolated position, where they are forced to address the media in order to channel their alarms on misconduct and mismanagement to policy-makers and to the public – and even in this case, they may not be able to provoke a reaction. In the case of the Southern Sweden University Hospital, preliminary findings indicate that negative media reports have had little response from policy-makers and hospital management and limited impact on public policy. Even when a top-down approach is adopted in public sector reform, some room for feedback is required for reasons of democratic transparency. This study highlights the importance of the feedback dimension of the policy process and the opportunities that this provides for whistle-blowing by professionals. More studies on this topic, in the context of public sector mergers, would be useful.

Conclusions

With autonomous public agencies, policy-makers are reliant on correct information from the agency management. However, these managers have incentives to always communicate progress, in order to avoid blame. Professionals, based on their professional ethics, may have the opposite incentives and wish to point out problems, referring to this as whistle-blowing. This whistle-blowing takes place in the feedback dimension of the policy process. This dimension has traditionally been neglected in the policy implementation literature.

This paper suggests that conflicting interests may influence what feedback is channeled through the policy process. This may not only hamper policy-making, but also democracy, as citizens may not be correctly informed of merger outcome. Similar to other studies (Heinrich, Lynn and Milward 2009) it suggests that government control and democratic responsiveness and accountability is gradually weakened, in the implementation of public policy.

Furthermore, findings suggest that managers in public sector reforms, such as hospital mergers, should be seen as actors with their own agendas and merely one out of many stakeholders, providing policy makers and citizens with information. Incentives for managers may differ from those among professionals. Whereas managers have an interest in showing a strong financial budget and also in showing that they are proactive and strong leaders, professional norms among physicians emphasize the quality of the provided services. In order to combine financial and quality incentives, and increase democratic transparency, the policy process can be strengthened by policy makers attending to the feedback from both these groups.

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