The Merger Decade
What have we learned from Canadian health care mergers in the 1990s?

A Report on the Conference on Health Care Mergers in Canada
Organized by the Ottawa Hospital and the Association of Canadian Teaching Hospitals
Additional copies of this conference report are available on the Canadian Health Services Research Foundation Web site (www.chsrf.ca) under Document Library.

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Mergers became a way of life in the nineties. In an effort to achieve financial savings and greater efficiencies, institutions in the private and public sectors alike have merged their resources, re-engineered their operations and created new cultures.

Health care is no exception to this modern phenomenon. In Canada, over the last decade more than 30 major teaching hospitals have merged into very large organizations. These mergers have been made under different models and conditions.

The idea behind mergers is to provide better patient care and save money. They’re also a way of responding to cutbacks the provinces felt were necessary to balance their budgets in a period of ever-increasing deficits. We are living the consequences of that political positioning — a kind of “merger madness” across Canada.

Last summer I discussed with a number of my colleagues the value of getting together for a meeting on whether hospital mergers are successful or not. As a consequence, an invitation was sent to approximately thirty members of the Association of Canadian Teaching Hospitals (ACTH), who’ve been involved in mergers. The response was really quite exceptional. Twenty-four CEOs agreed to speak at the conference — a significant proportion of the people involved in running our large Canadian hospitals.

The conference addressed the following major questions: Have we saved money? Are we providing better patient care? What works and what doesn’t work? How do we make a merger successful?

This report presents the results of the conference — the themes that emerged, the comments, concerns and reflections of CEOs running some of the biggest merged organizations in Canada. Not every problem was solved, but conference participants were extremely positive about the event: the general consensus was that the conference succeeded in providing important insight into the impact of mergers on our hospitals and healthcare system in Canada.

David Levine
President and Chief Executive Officer
Ottawa Hospital
The Canadian Health Services Research Foundation was delighted to be one of the sponsors of the Conference on Health Care Mergers in Canada and to prepare this report, including a set of research questions that arose from the discussions and presentations. We are grateful to David Levine and the Association of Canadian Teaching Hospital CEOs who made the conference possible.

We were particularly struck by how difficult it has been, because of the way mergers have unfolded, to do much systematic research along the way. We were, however, happy to bring in Jean-Louis Denis, of the University of Montreal, to summarize such research as is available.

In this summary, we have distilled the experiences and issues raised by the speakers and the audience into the eight research questions at the end of the report. If we can get going on that kind of research agenda now, we should have a better evidence base available for the health services sector when the policy cycle inevitably comes around to mergers once again.

Finally, we are particularly excited to communicate more widely the proceedings of the mergers conference with this easy-to-read summary designed for both researchers and health service executives. It’s a good example of the bridging the foundation does between those two communities. As a companion piece to this report, we are making available an annotated bibliography of literature on hospital mergers commissioned by the foundation.

Jonathan Lomas
Executive Director
Canadian Health Services Research Foundation
In St. John’s, when seven hospital kitchens were closed in favour of centralized food preparation, workers held ceremonies to mark the closure of their workplaces. The public “grieving ceremonies” gave some of the least-known workers in the system a chance to speak about their contribution to health care and — more important — the chance to acknowledge the pain when their worlds changed forever. It was an unusual public moment of recognition of the impact restructuring was having on their lives.

But thousands and thousands of people across Canada — from patients and their families to cleaners to chief executive officers — have had their lives, their workplaces and even their cities deeply changed by hospital mergers, usually without much time for reflection, let alone time to mourn.

Ottawa Hospital CEO David Levine decided to spark at least some reflection on mergers when he organized a national conference called Health Care Mergers in Canada — The Dos and Don'ts of Mergers.

Held in Ottawa at the beginning of November, 1999, and featuring more than 20 hospital CEOs as speakers, the conference attracted an audience of about 175 people. Panel discussions covered all aspects of mergers, from blending cultures to dealing with government, from the importance of communications to the impact of mergers on patient care.

The mere fact that it was the first such conference was a prime illustration of one of the main points that emerged over two days: there has not been nearly enough research or even sharing of information across the country on hospital mergers.

By the end of the three-day conference, steering a 14-foot sailboat through a hurricane was beginning to look easy compared to the turmoil brought about by hospital amalgamations.

When the process started, few Canadians had much experience of mergers and there was little guidance available. Experience has grown in the five years or so since restructuring became widespread, however, and several conference speakers had good ideas to offer on managing a merger. There were ideas on blending two or more corporate cultures, the importance of working quickly, the essential role of communications, the mistake of trying to bring about mammoth changes without an infusion of cash (indeed, speakers reported, almost invariably while money was being pulled out of the organization), and the very real question of whether mergers are achieving what they were supposed to.

“There’s not many published, empirical results of benefits [either financial or in quality of care],” Jean-Louis Denis of the University of Montreal told the conference. “It’s plausible, but not proved.”

What has been proved? What can we teach others? Have we learned at all?
For decades, healthcare was the chicken in Canada’s pot. Every election, spending was promised and politicians delivered: hospitals were built and enlarged and enlarged again. In those days before microsurgery, before many of the pharmaceutical breakthroughs that have changed the standard of care, hospitals were healthcare in many people’s eyes.

But the good times of the 1970s and 1980s had to end. Concern over public debt put the brakes on big spending projects and the recession that hit in 1991 stopped many of them altogether. Politicians in every province, desperately looking for somewhere to save money, noted that about one-third of their total spending every year went to the healthcare system.

The cuts began.

Simultaneously, other events were occurring that were to change the face of the healthcare system. Hospital beds were less necessary as recuperation times plummeted because of the new surgical techniques, homecare programs grew and pharmaceutical advances meant more people could have more of their conditions controlled outside hospital walls.

At the same time, the move toward regionalization began across the country. Driving it was a desire to rid healthcare of its ‘silos.’ Instead of money going to a hodgepodge of different institutions and care being dispensed with little co-ordination among all the various organizations, provincial governments (except for Ontario’s) decided that consolidating management of health in the hands of one board and set of executives would be more efficient both financially and for the patient: a variety of needs could be met by a variety of services run by one administration. In theory, it both acknowledged the change in the nature of healthcare, with its move away from hospitals to ambulatory care and also would put an end to people falling through the cracks. Under regionalization, the ideal was to get people the care they needed when and where they needed it from the most appropriate provider.

Still, it took the financial crunch to spur real change in the way hospitals operated in Canada. Before then, hospitals had discussed mergers and a few had joint administration or shared programs or a central kitchen or laundry service, but very little real change had taken place. Then, in 1992, Saskatchewan moved to close 52 hospitals. They were tiny (with an average nightly occupancy rate of four people each) but the writing was on the wall. The real shock waves hit a year later when British Columbia announced that Vancouver’s Shaughnessy Hospital, a major teaching hospital, would close. Merger, closure and amalgamation were the new reality for Canada’s hospitals.
It can’t be seen or touched or measured, but corporate culture, the all-pervading spirit of an organization that is a unique blend of myth, procedure and collective personality, is a real issue in hospital amalgamations. The loss of that culture is what people mourn in a merger and lack of a common culture can keep a new organization from succeeding. Yet culture is probably one of the most neglected aspects of change; its elusive nature is easily overlooked in a process that offers so many concrete demands every day.

Scott Rowand from the Hamilton Hospital Corporation quoted Terrence Deal and Allan Kennedy’s book, The New Corporate Cultures, to define culture as an “interwoven organic system of beliefs, values, rituals, personalities and mythology that creates meaning for people at work.” It matters, he said, because in a service industry such as hospitals, culture determines the performance of staff.

Mr. Rowand cited a study done on the re-engineering of Chedoke-McMaster Hospitals, now part of the organization he runs, by Christel Woodward and colleagues (distributed by the Centre for Health Economics and Policy Analysis at McMaster University). They found that as changes took place in the hospital, the morale of workers and their trust in the organization decreased markedly. The authors also refer to two studies, which found that “the climate and culture of an institution, the way their employees are treated, are related to quality of care delivered.”

In a merger, problems arise when conflicting corporate cultures are brought together. What emerges ideally would base the new culture on respect for the daily routines and special ceremonies of the former institutions, but that’s not done easily or quickly according to Lynda Cranston, former CEO of Children’s and Women’s Health Centre of British Columbia (created by a three-way merger.) To build a new culture, she focused on values the three hospitals shared, which were a common commitment to quality and the importance of helping patients while at the same time trying to avoid getting bogged down in the culture issue, when the focus should be on people and the bottom line.

A new culture cannot begin to develop until workers and professionals from the different institutions start working together. Although all employees suffer destabilization in a merger, physicians are the most important group when it comes to integrating cultures. It’s very hard to merge two hospitals unless the physicians and the new administration are in sync. In Sherbrooke, “downtown” doctors felt left out of a reorganization largely led by their suburban counterparts; Jean-Pierre Chicoine, CEO of the Centre universitaire de santé de l’Estrie, said they are tending to withdraw from the hospital altogether rather than adapt.

The best prescription most speakers could offer for building a new culture was to set clear goals for the new organization – goals that everyone is expected to meet. Measuring their success in doing so will reinforce the message that the future is what matters, not the past. Rome wasn’t built in a day, however, and several speakers warned that creating a new culture does take time. Many of the hospitals that have been amalgamated in this country are more than 100 years old and replacing those cultures, which have built up over decades, cannot be accomplished in a few months.
Hospitals are public institutions and have a responsibility to keep the public informed of their operations, but beyond that they are social services held particularly dear by Canadians, their most visible symbol that care is available. They are integral parts of the health system, but also, often, of the local economy. Any threat to their future is seen as a threat to the community and during the unsettling times mergers bring, the public demand for information is high.

Corporate communications are a challenge at any time, but particularly so when huge changes are occurring. They start at the top: the mantra of the chief executive officer must be communicate, communicate, communicate. Still, quality matters far more than quantity.

Effective communications are very carefully planned; the message, the target audiences and timing must be worked on, aligned and polished or the effort will not succeed. Silence, slapdash efforts or inconsistency will undermine the organization’s credibility. The goal is multi-faceted: to inform, to build trust, to win supporters and enlist champions for the cause.

Elisabeth Riley, president and CEO of the Children's and Women's Health Centre of British Columbia, offered the conference eight rules to attain those goals [see box]. It is clear that one size does not fit all; messages must be tailored to specific groups. People in what Ottawa Hospital CEO David Levine called “the zones of power” — internal and external, government officials, donors and patients on one side, the board, physicians and other staff on the other — don’t all have the same concerns and will be looking for different information. M.s. Riley referred in her paper to an article by Nick Taylor which suggested that other organizations can learn, as marketers have, that carefully aimed messages will have more impact: “Employees are not an amorphous mass that crosses the threshold into work and then leaves. They are people with individual needs, aspirations and abilities.... The old organization communicates in a ‘parental’ fashion, but today’s employees are adults and this requires a significant change in the way we communicate.”

It was repeatedly emphasized that physicians in

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**Elisabeth Riley’s Eight Commandments of Communication**

1. Communicate, communicate, communicate — you’ll never do enough
2. Content comes first — think before you speak
3. Messages must be consistent — make sure all managers are briefed
4. Words and actions must align — don’t just talk about integration, show it
5. Sending messages is not enough — you have to listen too
6. Use different strategies to suit different groups — each will have its own concerns
7. Acknowledge concerns — it shows you are connected
8. Honesty is the best policy — tell the truth and admit it when you don’t have answers
particular need to be addressed separately. They tend not to see themselves as staff, but they have enormous influence in both zones of power: within the hospital, they are authority figures, in the community they are trusted experts.

It is important to keep information flowing and messages consistent, but that can lead to problems because too much information early on may lead to apparent back-tracking if circumstances later change. In any case, flexibility is required because messages will change through different phases of the merger. Staff should always be told of change first, or at the very least at the same time, as outsiders; but at all times senior managers need to be well-briefed so the ideas they present are in agreement. From among their ranks may come what M r. Levine called “champions,” people as capable of carrying the hospital’s messages out to the community as the CEO. A vice-president of communications, physician leaders, board members and academics can also play that part.

Not even a large group of champions can substitute for high visibility on the part of the CEO, however. Across the country, CEOs who have led mergers have made it their business to be out and about, in the halls, at staff and community meetings and ready to talk about changes any time, anywhere. One CEO in a newly created New Brunswick health district logged thousands and thousands of kilometres travelling long distances between the different institutions being brought together under one board. It hardly left time for his administrative duties, but he knew that drawing people together could not be done from a central office a hundred kilometres down the road.

Communication is not, however, a one-way street. While it is important for the CEO to be highly visible and to appear at a lot of meetings, it must be clear that he or she is listening and responding as well. Some opened special e-mail boxes for direct questions from staff and made a point of answering them all.
One thing that would really smooth the path of most mergers is money. Paradoxically, one thing that merged hospitals are almost invariably short of is money, because whatever the theory behind them, in the end what triggers most mergers is usually the need to cut costs.

“You have to have a lot of wires that don’t completely touch to believe you can merge two institutions and not come up with start-up costs,” said Neil Roberts, who was at the helm of the Queen Elizabeth II Health Sciences Centre in Halifax when its merger began. Yet in virtually every instance, budgets were actually cut and there was certainly no chance of start-up financing when hospitals restructured.

That leads to what Hugh Scott, CEO of the McGill University Medical Centre said was a struggle to reconcile: the need to be free to think in innovative ways and the restraints of cost cutting. “At best, there’s cognitive dissonance. At worst, it’s sheer schizophrenia.”

Money can’t compensate for organizational and cultural problems, said researcher Jean-Louis Denis, but it does ease transitions by making it possible to implement new projects and win people over to new programs.

**TIME IS OF THE ESSENCE**

Moving fast is the key to successful mergers, said John Tory, president and CEO of Rogers Cable (invited to the conference because of his expertise in private-sector takeovers.) The faster a merger is, the less painful it will be, while delay “breeds a lack of integration and postpones tough decisions,” he said.

Mr. Tory acknowledged that it’s a lot easier for a private business to move quickly than for hospitals or governments — a point supported by John Horne, chief operating officer of the Health Sciences Centre in Winnipeg, who told the conference “The road to reform was characterized as a slow lane with bumper-to-bumper traffic, and where there was a fast lane, it had speed bumps.”
Mergers within Mergers

However thorough the negotiations and careful the planning, hospitals don’t spring fully formed from merger agreements. The real restructuring comes about through a series of micromergers, the incremental melding of departments and programs within merged hospitals that happens after the formal amalgamation is made official. After the legal work is done, negotiations must begin to unite, one by one, everything from clinical programs to laboratories, food services and laundries. Sometimes that means all the workers in a given department are moved to one site; in other hospitals, they remain operating in separate locations but are united under one management team.

Alan Hudson, CEO of what is now Toronto’s University Health Network said that for years after the merger of Toronto General and Toronto Western hospitals, low-level negotiations were going on between departments. Individually small, the impact of those micromergers over the years was as great in the aggregate as the original merger and every one of them should receive as close attention as the original deal, he said.

Jean-Louis Denis of the University of Montreal said clinical reorganization is best managed through a series of micromergers. He recommended starting with those easiest to negotiate and most likely to succeed, in order to have good examples for subsequent efforts and to help maintain a balance between planning and implementation. In his 1999 paper on hospital mergers, he warns that planned micromergers work better than those precipitated by a crisis, such as staff leaving the hospital. He adds, however, they can also precipitate loss of staff: “Each unit or department develops through time a kind of community of practice where patterns of behaviour and professional relations take idiosyncratic forms. Professionals are strongly attached to these patterns, so much so that attempts to alter them often lead to exit or withdrawal rather than change.”

Brian Lemon, CEO of the Capital Health Authority when Edmonton’s health services were being united, said he thought that amalgamation worked because those negotiations were done by mixed teams of staff — people from different disciplines and different sites who worked together to plan the micromergers of each department or program. Decisions were made by consensus and if a team couldn’t reach consensus, it lost the right to make the decision.

It was generally agreed that micromergers need very careful management — but in too many cases have been left to manage themselves in the wake of an amalgamation.
Leadership and Governance

In Canada, hospitals are creatures of provincial governments. Although within their walls, and even within the community, they seem to be operating fairly autonomously, that is more illusion than reality. Perhaps the extreme is Quebec, where the salaries of individual management positions are set by the province, but across the country, nurses’ wages are bargained province-wide, permission to buy and operate certain types of equipment — even what programs or services can be offered — is at the discretion of the provincial government.

Because most hospitals started out as independent institutions, later absorbed by provincial health systems, they have maintained their boards, with their responsibility for overseeing operations, fundraising and creating links with the community. Boards, in turn, appoint CEOs. It was for many years a fairly straightforward division of roles and power.

Restructuring threw those comfortable relationships into upheaval so that in a merger, leadership and governance become more important than ever before. Governments initiate hospital restructuring and they can mire it down. Trustees can craft a new hospital from a tangle of parts, or they can bring so much baggage to the boardroom you can’t get in the door. CEOs can rally the troops, or they can drive them out.

At the conference, it became clear that even the best-planned mergers can be stymied by the vicissitudes of government behaviour. It’s often governments that instigate mergers, set their goals and devolve the authority to make the changes. Decisive government action is crucial for launching mergers and continued commitment to making them successes. Too often, fear of political repercussions or the loss of political will in the face of an impending election can undermine years of work, while a change of government or political interference can derail even mergers that seem to be well on track.

The role of boards is also severely tried in a merger. A board should be the liaison between the hospital and the community, the public face that wins support from government, patients, the business community and the public in general. The board must develop policies and strategic direction in response to the province’s orders, translating that into guidance for the CEO. The reality has not always run smoothly. It now seems clear that the elaborate schemes worked out in many mergers to combine boards — usually a set number of seats apportioned to representatives of each of the former hospital boards — have not served amalgamations well. In an effort to represent all the involved parties, they are often too big to function smoothly. And on the amalgamated boards (perhaps naturally, after years of service to one institution) many trustees cling to old loyalties as though they are there to protect the interests of their old organization, rather than governing a new one.

While no clear model for how to design a board and who might make the best trustees in a transition has emerged, the consensus at the conference was that a fresh group of volunteers, ready to back the actions of a CEO who comes from outside any of the amalgamating hospitals, can do much to make a merger work. John McGarry, CEO of the Region 3 Hospital Corporation, attributed at least some of New Brunswick’s success when it created health regions to the government’s removal within days of existing trustees from office, before resistance had a chance to build.

However, while leadership from the board is important, it must not extend to an active role in management, no matter how tumultuous the times.
Whether because of pressure from the public or the staff, or from a genuine wish to help out a beleaguered CEO, board members have a tendency to try to get involved in management during mergers, which in the long run does not make the amalgamation any easier.

But boards and governments notwithstanding, it is the CEO who is the public face of leadership in a merger. Decisive action, with the “ability to lead through chaos” as Sunnybrook and Women’s David McCutcheon put it, are essential characteristics of a CEO whose role in the merger is to set the tone that will win support for the new institution from the staff and the community. Being visible and accessible at all times (talking to people, it was agreed, isn’t enough; real listening and empathy are required too.) Sometimes an interim appointment can smooth the new CEO’s path by providing a lightening rod for the worst storms of the transition, before the permanent appointee arrives, although some argue that a permanent appointment gives a CEO more authority from the start.

Although CEOs have to work with people inside and outside the institution, keeping them informed and winning support for change, no one’s support is more important than that of physicians. Within the hospital, their support and commitment are key to redesigning programs and re-allocating resources. While outside, they can shape community opinion for good or ill. They must be won over for an amalgamation to work. In New Brunswick, the government compensated physicians for the time they spent on planning boards and committees, so they were not out of pocket for helping to make the changes — a small but significant step to gaining support.

But above all, a CEO must be able to articulate and champion a clear vision for the future, clearly expressed. Most important, according to Tony Dagnone, CEO of the London Health Sciences Centre, is the ability to keep one’s eye on the goal. “You have to focus all the time, or you will be divided and conquered by people jockeying for position.”
Measure for Measure

Most people will tolerate a painful treatment in hopes of a cure. But has the treatment dished out to the ailing healthcare system actually helped? Are we doing the right thing? Mergers were intended to improve health care and save money. Have they succeeded in achieving either goal and how are we supposed to know if they have? These are huge questions, at the core of any research agenda on mergers and one which people across the country are trying to answer.

Neither cost savings nor improved health outcomes are easy to measure and in any case, there is certainly no agreement on what should be measured and what comparisons are valid in assessing a merger’s success. A merger may reduce a hospital’s operating overhead, but at the same time increase expenditures on homecare and pharmaceuticals. A more efficient ambulatory-care system can mean that only very sick people are in-patients, so the cost per case may increase and soak up any savings hoped for in an amalgamated hospital’s budget. Assessing whether health care has been improved is even trickier. What degree of health must a patient attain to have had a good outcome from a hospital stay? What might feel like a miracle recovery to one person may be a complete disappointment to another.

Ideas of health, too, have changed. Once, the results an institution got for each patient it treated would have been enough to define health. The creation of regional health authorities, however, and acknowledgement that health is determined by a variety of social and economic factors means success or failure of a healthcare system cannot be determined by such easy-to-measure factors as readmission rates or length of stay. Even patients are not what they once were; in some cases, the patient may be an entire family.

There is no shortage of information available. Indeed, statistics abound: there is tracking of medical outcomes, of patient visits, of the number of procedures, of budgets cut and money redeployed. And there are endless surveys of more amorphous issues such as patient satisfaction and staff morale. However, there is one common flaw: few, if any hospitals did similar studies before their mergers. Without a baseline, it’s not possible to measure improvement. There isn’t even agreement on terms, since what is meant by the word merger may be defined differently from place to place and few people have actually decided what outcomes they would consider a success.

Those complications don’t mean that officials are off the hook, said Sister Elizabeth Davis, CEO of the Healthcare Corporation of St. John’s. “We are messing with some of the most vulnerable of all social institutions in our country,” she said. “The public is very interested in those institutions and we are changing them dramatically. We have to be more accountable.” We may know intuitively that the greatest promise is with mergers, she added, “but we can’t prove today that health care mergers are successful.”

Most CEOs at the conference reported trying to decide what their goals were and setting standards to be met so they could measure their success. Even in the absence of pre-merger data for comparison, such an exercise has an important psychological aspect: If the best way to get the staff to pull together is to set clear goals for them to strive toward, you have to measure the results to show them how they’re doing.

There are also measurements to be taken that are extremely difficult to quantify but which perhaps outweigh any other, and those are the measurements that tell you how people feel about what’s happened. David McCutcheon, of Sunnybrook and Women’s, quoted General Electric’s high-profile CEO Jack Welch, who once said “There are three things to take care of in a merger: customer satisfaction, employee satisfaction and positive cash flow.” The latter is not quite relevant to the non-profit sector, but the first two are very important. Satisfied patients mean a supportive community; happy employees are likely to work better. The University Health Network in Toronto is a case in point: CEO Allan Hudson considers the new entity (it is an amalgamation of four other hospitals) a success financially, operationally in quality of care, but admits that surveys show patient satisfaction with the changes is not very good.
Montreal researcher Jean-Louis Denis studied mergers in two teaching hospitals and came up with four tasks critical to the success of creating a functioning organization from a merger:

• Rebuild the executive team so natural reluctance to work with someone who has taken the place of a colleague is overcome and the team can cooperate when facing challenges.

• Connect the new leadership with people throughout the organization, generating confidence, setting the rules of the game and defining responsibilities clearly.

• Work out the clinical reorganization through micromergers that unite departments incrementally after the official merger. Successful micromergers of different clinical specialties are important symbols for newly merged organizations.

• Build good support for the merger outside the hospital, best done by a board that can win community support and build a common vision for the future.

Speakers at the conference had their own keys to success:

• Get decisive support from government; political waffling can derail merger efforts.

• Create a simple board structure with trustees who support the merger and the CEO who is leading it.

• Move quickly. The tendency of governments to drag out decisions undermines efforts to change.

• Don’t get bogged down by too much planning — at some point, sooner rather than later, it’s time to stop talking and act.

• Set clear goals, and keep reminding yourself why you did the merger in the first place.

• Try to negotiate start-up funds — mergers work better when there’s money available to make changes work.

• Communicate often, with well-thought-out, consistent messages delivered promptly and tailored to your audience.

• Celebrate what you can — successes when you have them, new beginnings, whatever. Involve people in what’s new to lessen their preoccupation with what’s gone.

Endnotes
Questions arose throughout the conference for which no one had the answers. Researching those questions may help CEOs of the future if (when?) they face merging. The most pressing research questions arising from the conference were:

1. What is the definition of culture in the context of health services organizations? How does it influence morale, costs, service and effectiveness?

2. What is the process of cultural change and what mechanisms speed the stabilization of a new culture in a merger?

3. What conditions favour amalgamation of health-care services? What conditions can facilitate amalgamation? What type of support do institutions need?

4. What types of communication strategies win support for a merger from the staff and the community?

5. What are the medium and long-term impacts of merging hospitals on the local economy, access to and costs of services, quality of care, patient outcomes and satisfaction, quality of teaching, clinical work and service teams?

6. Can the effects of mergers in different institutions be compared? On what basis? Can the results be generalized to other institutions?

7. Are different approaches (and different impacts) indicated for voluntary vs. involuntary mergers?

8. Are the issues the same for all the micromergers of all the different departments and programs as for the main hospital merger?
Conference Speakers

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Bryan Health Interests
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Robert Busilacchi, D.G.
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David Carlin, President & CEO
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Cécile Cléroux, D.G.
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Lynda Cranston, CEO
Canadian Blood Services
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Tony Dagnone, CEO
London Health Sciences Centre
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Sister Elizabeth Davis, CEO
Healthcare Corporation of St. John’s
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Dr. Ginette Gagne-Koch (former) CEO
Region 1 Hospital Corporation
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Dr. John Horne, CEO
Health Sciences Centre
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Dr. Alan Hudson, CEO
The University Health Network
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Brian Lemon, CEO
Lakeridge Health Corp.
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