The Alchemists: A Case Study of a Failed Merger in Academic Medicine
William T. Mallon, EdD

Abstract
The changing environment in health care delivery and reimbursement in the United States in the late 1980s and 1990s caused a massive overhaul in the organizational structure of health care institutions. Hospital mergers were commonplace. Physician practices were bought and sold. Once stand-alone institutions developed integrated delivery systems. The academic medical community investigated and pursued a number of strategies to address changes in the marketplace, including streamlining and reengineering business practices; centralizing and integrating operations and decision making; creating separate clinical enterprises; creating new public authorities or nonprofit corporations to govern hospitals; building networks of providers; and acquiring physician practices. Perhaps the most hyped strategy was consolidation.

In 1997, Pennsylvania State University’s Hershey Medical Center and Geisinger Health System in Danville, Pennsylvania, announced plans to merge into one large clinical enterprise. The merger unwound three years later. Based on extensive interviews and document analysis, this case study examines six aspects of the merger and de-merger between Pennsylvania State University and Geisinger: (1) the environment and historical context that preceded the merger; (2) the reasons for the merger; (3) the structure of the merged system; (4) the outcomes for the new organization; (5) the reasons for the dissolution; and (6) the lessons learned from this series of events.

In 1997, officials at the Pennsylvania State University (Penn State) Hershey Medical Center and the Geisinger Health System in Danville, Pennsylvania, attempted to meld their two organizations into a new entity. They endeavored to create an institution that could survive and even flourish in a rapidly changing environment. Underlying their attempt was an interest in developing a national model of health care delivery. Their efforts proved unsuccessful. In this article, I examine the circumstances, process, and outcomes of the merger and its dissolution. Based on extensive interviews and document analysis, this case study examines six aspects of the merger and de-merger between Penn State and Geisinger: (1) the environment and historical context that preceded the merger; (2) the reasons for the merger; (3) the structure of the merged system; (4) the outcomes for the new organization; (5) the reasons for the dissolution; and (6) the lessons learned from this series of events.

The Case Study
In this case study, I used a qualitative methodology to investigate a complex organizational process. Qualitative research “assumes that there are multiple realities—that the world is not an objective thing out there but of function of personal interaction and perception.” Case study research is particularly appropriate to describe an event, situation, organization, or people in great detail. Such was the goal of this study. I describe the data sources for this study below.

Interviews
I conducted extensive personal interviews with the key individuals involved in the decision making process of the merger and de-merger. (See Appendix for a list of interviewees) Because it is important to portray differing views in a case study, “the interview is the main road to multiple realities.” The purpose of each interview was to obtain the individual’s story of how the two institutions came together and then fell apart. I conducted the interviews using a focused interview approach, a set of semistructured, open-ended questions to elicit comments on particular topics. Thirteen individuals participated in interviews in Hershey, Danville, and University Park, Pennsylvania, and in Washington, D.C. I audiotaped ten of these interviews and later transcribed the tapes verbatim (three interviews were not audio-recorded). Each interview lasted between 45 minutes and 2 hours. I interviewed an additional five individuals by telephone and recorded the details of these interviews in handwritten notes.

Written documentation
The other primary source of data for this case study was extensive written documentation, including institutional press releases, internal memoranda, reports, newspaper articles, and other published stories and accounts of these events. I obtained this documentation from individuals, institutional records, and online databases.

The Context: The Changing Environment of U.S. Academic Medical Centers in the 1990s
The changing environment in health care delivery and reimbursement in the United States in the late 1980s and 1990s caused a massive overhaul in the organizational structure of health care institutions. As managed care spread from West to East, a new model emphasized primary care physicians over specialists and introduced price competition into the marketplace. As a result, hospital mergers were commonplace. Physician practices were bought and sold. Once stand-alone institutions developed integrated delivery systems. Indeed, the 1990s were marked by an industry-wide transformation.

Academic health centers (AHCs) faced enormous challenges in this new...
environment. With their immense power, health plans were reluctant to enter into contracts with academic centers because of their higher costs. Referrals to AHCs from community physicians and hospitals began to decline. As volumes dropped, so did clinical revenues. And as clinical subsidiaries that supported the teaching and research missions declined, the funding infrastructure that supported the whole academic medical enterprise was threatened. In the mid- to late-1990s, AHCs also faced reductions in Medicare spending, jeopardizing the levels of subsidies they received for graduate medical education and indigent care.

The academic medical community investigated and pursued a number of strategies to address these changes in the marketplace. Among the solutions were streamlining and reengineering business practices; centralizing and integrating operations (billing, practice plan administration) and decision making; creating new, separate clinical enterprises; creating new public authorities or nonprofit corporations to govern hospitals; building networks of providers; and acquiring physician practices.5

At the time, the literature was awash in advice. Experts and prognosticators issued warnings to academic medical center leaders that “the status quo is not tenable”6 and “integration is inevitable.”7 Academic health centers were told that they needed either to adapt-by growing their reach and influence—or to shrink—by jettisoning their clinical facilities.8 Harrison et al.9 reported three strategies: (1) “do it alone” by creating a self-contained integrated delivery system; (2) form alliances or mergers with community hospitals and programs; and (3) separate the college of medicine from the teaching hospital by selling the hospital to a for-profit company.

Many AHCs pursued these tactics. Medical schools that sold their hospitals to for-profit companies included Creighton University, University of Southern California, St. Louis University, and MCP Hahnemann (all to Tenet Health care); Emory, Tulane, and the University of Oklahoma (all to Columbia/HCA); and The George Washington University (to Universal Health Services). An even larger number of academic health centers—including Jefferson Medical College, Medical College of Georgia, and Georgetown, Indiana, Kansas, Nebraska, Oregon, and Wisconsin universities—changed the teaching hospital governance from common university ownership to a private, nonprofit, or independent authority.10

Perhaps the most hyped strategy was consolidation. Mergers and acquisitions first affected banking in the early 1980s and swept through other industries in succession. The literature suggested the consolidation through organized health care delivery systems was integral to medical center survival.11,12 “Forward and backward integration is a viable strategic move for every major player in the health care system” argued one commentator.12 Industry-wide, hospital mergers were plentiful. According to one source, nonprofit hospital mergers and acquisitions increased from 30 in 1994 to 153 in 1997.13 In academic medicine, the most discussed mergers included the Medical College of Pennsylvania and Hahnemann School of Medicine under the auspices of the Allegheny Heath, Education and Research Foundation; the teaching hospitals of Stanford University and University of California San Francisco; and the Massachusetts General and Brigham and Women’s hospitals.14,15 Other mergers or alliances took place between the University of Cincinnati University Hospital and the Health Alliance of Greater Cincinnati;9 the University of Massachusetts Medical Center and Memorial Health Care;16 Beth Israel Hospital and Deaconess Medical Center, New York Hospital–Cornell Medical Center and Columbia-Presbyterian Medical Center, and Penn State University Hershey Medical Center and Geisinger Health System, to name a few.

Many mergers in both academic and private settings did not live up to expectations. In a study of 300 of the 750 for-profit and nonprofit hospital mergers that occurred between 1994 and 1998, the consulting firm McKinsey & Co., concluded that most had failed.13 Beginning in the mid- to late-1990s, a different tone began to appear in the literature: warnings about unrealistic expectations for health care delivery systems, cautions about the sustainability of managed care, and commentary about the folly of “merger mania.”13,17–19

The Penn State-Geisinger Health System Merger

The merger between the Pennsylvania State University Hershey Medical Center and the Geisinger Health System (GHS) arose in this context of a rapidly changing health care environment. Each institution had been searching for ways to ameliorate their vulnerabilities in the marketplace.

Penn State University College of Medicine

The Pennsylvania State University College of Medicine was founded in 1963 with a $50 million grant from the Milton S. Hershey Foundation. An additional $21.3 million from the U.S. Public Health Service enabled the university to build the medical school, teaching hospital, and research center. The first medical student class enrolled in 1967 and the first patients were admitted to the medical center in 1970. The state legislature approved the medical school with the pledge from the university president that Penn State would not request state appropriations for the medical center.20 But by the early 1970s, it became apparent that university officials had underestimated the costs associated with running medical education and clinical programs. While the state approved a modest per-student funding formula, the appropriation did not change for more than a decade20 and has remained relatively low for the history of the medical center. In 1996, the medical school ranked 73rd among the United States’ 74 state-supported medical schools in state appropriations.21 Additionally, as a relatively new medical school, Penn State did not have large endowments or alumni giving from which to draw.

By the mid-1990s, Penn State was suffering from the changes in the health care market. State funding accounted for less than 3% of revenues; the medical school had developed a strong reliance on the clinical enterprise to fund the education and research missions. Financial analysts projected that clinical operating margins of greater than 12% were necessary to maintain historic levels of support for the academic missions.22 Yet, managed care was reducing those margins. The medical center’s forecasts suggested worse was yet to come, anticipating that managed care utilization
would increase from 13% in fiscal year 1996 to 49% in fiscal year 2001 (see Figure 1). The institution’s leaders felt the long-term survival of the academic mission was at risk.22–24

Like many academic health centers, Penn State began to search for collaborative relationships to ensure its survival. “This region, the state, and maybe the whole country were coming directly under the influence of market health care reform. There would be a consolidation of carriers. We thought we would be in a much better competitive position if we were larger and stretched over a broader area. We wanted to dominate the market.”23 Leaders also wanted to develop a financial return system that would ensure a clinical revenue stream to support the college’s academic missions.23 Explorations of partnerships with not-for-profit and for-profit health plans proved unsuccessful because of lack of interest or unwillingness to support the academic mission.25

Geisinger health system

Through the generosity of Abigail A. Geisinger, the Geisinger Memorial Hospital opened in 1915 in Danville, Pennsylvania, with the mission to “always care for the man of toil.” Over time it evolved into the Geisinger Health System, an organization of hospitals and clinics devoted to the health of rural Pennsylvania. The Geisinger Health Plan (GHP), one of the earliest health maintenance organizations in the country, began in the early 1970s and grew into the largest rural managed care plan in the country.26 By the mid-1990s, GHS was a group practice of 600 physicians, covering a service area of 31 counties in north central and northeastern Pennsylvania. GHS facilities consisted of a 548-bed medical center and a children’s hospital in Wilkes-Barre; and a drug rehabilitation facility.

The changing health care industry had repercussions for Geisinger as well. The health system realized net profits in the mid-1990s but was not immune from cost pressures, eliminating about 250 positions in the early- and mid-1990s.27 The integrated delivery system—doctors, hospitals, and insurance plan—emerged as a “fundamental market strategy” for Geisinger executives.28 But the growth of the GHP began to slow. In 1996, for the first time in a decade, the health plan enrollment actually decreased.29 Additionally, the mid-1990s was a time of competitive insurance underwriting; from 1996 to 1998, GHP did not increase its premiums.30 To be effective in the marketplace, Geisinger needed to expand its insurance plan’s coverage geography. One projection indicated that the health plan needed to grow from fewer than 200,000 to 600,000 covered lives by the year 2000 to remain independent.29 Geisinger considered collaborative relationships with other hospitals and medical centers. The 2.1 million people in the nine-county service area of the Hershey Medical Center were particularly appealing to Geisinger executives: “The market that Hershey represented was a younger, growing, more dynamic population” than its traditional market.31 Geisinger “would have established a delivery system in a large, relatively populated area on the south side of Pennsylvania where we had no entry. So Geisinger would be able to grow its business model.”28

Merger discussions

Penn State and Geisinger considered a partnership several times in the 1990s. In August 1993, executives of the two organizations met and contracted a consulting report, which concluded that opportunities for collaboration did not yet exist. In February 1995, another management consulting study evaluated the potential for affiliation, but none materialized. In late spring 1996, however, the two chief executive officers again decided to explore a range of collaborative opportunities. They each appointed a four-person team. A series of confidential meetings began in July 1996 in Pine Grove, Pennsylvania, halfway between Hershey and Danville. Secrecy was paramount; correspondence referred to the negotiations by code name. The two chief executive officers (CEOs) charged this group to “think out of the box” and “talk about things like mission, vision, values, strategy, to see if we have some common interests in commitment.”23,28 By early fall, the eight-person group was considering a serious collaboration. They needed to involve both CEOs. At one meeting, the Penn State senior vice president and dean said to the Geisinger CEO, “Why don’t we just merge?”23,31

In September 1996, the discussion group was expanded to include the chief financial officers, attorneys, other leaders, and a consultant who served as facilitator. For the remainder of 1996, the group—still operating in secret—developed a term sheet and memorandum of understanding to combine the two clinical enterprises into a new organization, to be called the Penn State Geisinger Health System (PSGHS).

The merger team reviewed financial analyses, conducted due diligence, and negotiated the details of governance, leadership, and human resource issues. In November 1996, the CEOs informed their respective board members about the negotiations. The two boards voted unanimously to approve the merger on January 17, 1997; the merger was publicly announced on the same day. Initial media reaction was generally favorable, although there were reports that some faculty, staff, and community leaders were upset because of the secrecy of the deal.22 The merger created an organization with nearly $1 billion of net operating revenue, 1,345 licensed beds, over 13,000 employees, and nearly 1,000 physicians (see Table 1).

Reasons for the merger

Both organizations pursued the merger because of the chaotic health care situation in the 1990s.

![Graph](image-url) - Figure 1 Pennsylvania State University Hershey Medical Center’s projection in December 1995 of managed care utilization for fiscal years 1996–2001.
environment discussed earlier. Both bought into the idea that large consolidated entities were the wave of the future for Pennsylvania and predicted that there would be only “five or six surviving health care systems.” The belief was “that bigger was better.” Both institutions wanted to strengthen their clinical enterprises, improve market position, and save money. To this end, they projected savings of more than $100 million during the first three years of the merger, with initial savings of up to $20 million. Curiously, leaders also indicated that no existing facilities would close and job layoffs would be minimal.

Each organization had its own reasons for the merger as well. For Penn State, these included preserving and maintaining the academic mission, maintaining financial viability of the College of Medicine, avoiding imposing greater financial burden on the university and the commonwealth, and enhancing market position. Geisinger Health System’s reasons for merging included creating a larger, geographically expanded health service organization for contracting leverage and attracting collaborative partners; consolidating existing and prospective expense; expanding service capacity to grow the Geisinger Health Plan in new markets; enhancing political influence; and enhancing external grant funding for basic and health service research.

A cursory examination of these rationales suggests that while the two organizations had some common goals, they also had foci that were quite divergent. At the most fundamental level, Penn State’s objective was to secure a funding stream for its academic mission; Geisinger’s was to expand its clinical programs into new markets, using its health plan as a prime business strategy. These differing goals were noted, in hindsight, by some decision-makers. As one stated, “The deal was clearly structured as dollars for control of a clinical enterprise. The obligation on the part of the health system was to give $40 million a year—give or take a little—to the College of Medicine. But the quid pro quo was that Penn State was clearly giving up the entire control of its clinical operations.”

### Structure of the Penn State Geisinger Health System

The merger formally occurred on July 1, 1997. The negotiations resulted in unique patterns of organizational governance, leadership, structure, and financing.

#### Governance

Each partner appointed half of the 16-member board of directors. The existing Geisinger board chair was appointed as chair of the new organization and had an extra tie-breaking vote. For its slate, Geisinger appointed current board members. Penn State appointed five current members of its board of trustees, one member who had been on the College of Medicine’s board of visitors, and two members with no previous relationship. At that time, the vast majority of the PSGHS board of directors had strong allegiances to one of the two original organizations. (In 1998, upon one board member’s departure, Geisinger appointed a new individual without a previous Geisinger affiliation who was viewed as a neutral party.

The Geisinger negotiators insisted on the board structure because, in the words of the CEO, “This was an issue of control. Quite frankly, my board said if we were going to put the assets of the Geisinger Health System on the line in a relationship with Penn State University, then we are going to have control of the assets going in.” Penn State consented because the Hershey Medical Center brought no balance sheet or economic assets to the affiliation. No state assets were transferred to the new system. In effect, Geisinger financed the merger, and as a result, demanded and received ultimate control of the board.

#### Leadership

The existing leaders of each organization remained in place in the new entity. The CEO of Geisinger was appointed CEO of PSGHS; the senior vice president for health affairs and dean of Penn State became the president and chief academic officer. Rounding out the new senior leadership team was the executive director of University hospitals and COO of Hershey Medical Center who became the chief medical officer; and the chief operating officer of GHS who maintained the same role in PSGHS.

#### Organizational structure

The Hershey Medical Center was subsumed into the regional organizational structure of PSGHS, forming a south-central region and joining three other regional hubs (see Figure 2). The majority of clinical employees at Hershey Medical Center were transferred out of Penn State employment to PSGHS. Physician faculty at the College of Medicine became dual employees paid through a common paymaster system. Penn State University maintained ownership and financial responsibility for the College of Medicine; basic science faculty and some administrative staff, for example, remained Penn State employees. While the new health system took control of all clinical operations and responsibilities,
Penn State required that the responsibility for PSGHS’s “educational and research activities . . . be vested in the College of Medicine.”25 Penn State also became the trustee of the PSGHS Foundation.

**Academic support formula**

A crucial component of the merger for Penn State was the development of the academic support formula for the medical school. The formula directed PSGHS to provide funding to the medical school based on a three-part scheme:

1. A fixed-base component. For fiscal year 1998, the base was $31.7 million. The formula stipulated that the base amount would increase by 1.5% annually for the subsequent five years;

2. A revenue-sharing component, equal to 0.525% of operating revenue; and

3. A profit-sharing component, consisting of 20% of the net operating margin over 2.5%.

College of Medicine officials anticipated that the academic support formula would generate payments to the medical school of $45 million in fiscal year 1998, growing to $51 million by fiscal year 2001 (see Table 2).33

**Merger of equals?**

The structure of PSGHS gave the appearance of equality in board and executive leadership but raised the question of whether the merger was, in fact, a merger of equals. Nearly every person interviewed about the events indicated that, in hindsight, the answer was no:

They [Geisinger] brought the balance sheet into the merger and we didn’t. They retained ultimate control on the board and had the CEO . . . At the end of the day, they controlled the organization.24

Hershey physicians felt strongly that they were taken over.39

There is probably no such thing as a merger of equals. somebody’s got to be in charge in the end.40

We used that term a lot. We said, “Oh, yes, we are going to figure this one out. We are smart enough.” In retrospect, that is a bit of arrogance. We should have listened. . . . There is no such thing as a merger of equals. It is always an acquisition or perceived as an acquisition.23

I think we had the strength more than Hershey. If you look at who had the management structure, who had the administrative systems, it was all Geisinger’s.31

**Developing Problems**

The merger survived three years. Tensions erupted almost immediately in many areas of the health system’s management and operations. Participants in this case study discussed many significant issues that created stress on the system. In this section, I review four problems most frequently cited by individuals in many areas in the organization.

**The health plan**

The health maintenance organization was the primary business strategy for the merged health system.28,29 Health plan executives stated that the merger was “a straightforward expansion opportunity... The idea is to grow GHP down in that region.”41 HMO officials hoped for 50,000–60,000 members in the Hershey region in the first two to three years. But the strategy for expanding the health plan into the counties surrounding Hershey proved problematic. Immediately upon the new system being launched, local physicians became outraged and community hospitals rejected the advancement of the health plan.23,28,42 One interviewee said, “They simply shut the plan out.”53 In response, PSGHS built clinics in several surrounding counties.

“We invaded their territory, clearly violating our previous friendly relationships,” asserted one participant.22 As a result, the Hershey Medical Center and its specialists lost referrals and revenue. The PSGHS chief executive summarized the situation: “The fact that we had difficulty selling our health plan in the Hershey region was a problem. Not only did it put pressure on us financially, but it created real contentiousness between Hershey faculty and their colleagues in the community.”28

**Financial difficulties**

Financial difficulties presented a second immediate (then ongoing) crisis. The Balanced Budget Act of 1997 had a severe negative impact on academic health centers and hospitals throughout the country. Its passage coincided with PSGHS’s embryonic stage, tossing the organization almost immediately into financial distress. “We needed a little bit more time to get our sea legs planted before we were ready for that,” noted an interviewee.22 While the financial situation was similar to constraints felt by hospitals across the country, it was especially difficult for an organization in its most nascent stages. In fiscal year 1998, its first full operating year, the

**Table 2**

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Projected payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>$45,440,000</td>
</tr>
<tr>
<td>1999</td>
<td>$47,790,000</td>
</tr>
<tr>
<td>2000</td>
<td>$49,440,000</td>
</tr>
<tr>
<td>2001</td>
<td>$51,140,000</td>
</tr>
</tbody>
</table>

Adapted from data provided to the author by Zolko WW.23

---

**Figure 2** Organizational structure of the Penn State Geisinger Health System.
health system made a profit of $12.5 million on revenues of about $1 billion. The next fiscal year was worse: a $6.6 million loss on revenues of $1.15 billion. By October 1999, the health system announced plans to eliminate 500–600 positions.

**Disputed decision making**

As early as October 1997, the original negotiating team had to be reassembled because of disagreements between Hershey and Danville over responsibilities and authority. For everyone in the system, but especially the Hershey clinical chairs, the new merged system represented a challenge to familiar decision making traditions and styles. For example, the Hershey clinical chairs typically operated with considerable autonomy, budgetary discretion, and ability to maintain reserve funds. As one interviewee noted, the Geisinger model prohibited many of those activities: “They did not have access to funds carte blanche. . . . We viewed their open access to funds to use almost any way they wanted as presenting business risk to the organization.” The Geisinger decision making model featured participatory management but with a different emphasis than the shared governance model to which Hershey chairs were accustomed. These different cultures in the two organizations were manifested in disagreements about who had responsibility and authority for various decisions.

In 1999, in response to its continued bleak economic forecast, PSGHS began cost-reduction strategies like many academic health centers and health systems at the time. The PSGHS reengineering program, dubbed APEX (Accelerated Program for Excellence), featured a steering committee that would vote on recommendations to close or consolidate programs. Its vote, in turn, served as a recommendation to the CEO, who was the final decision maker. Because of the ambiguities in the merger terms, however, there was not agreement among senior leaders or the board where PSGHS’s clinical decision making responsibility ended and the College of Medicine’s authority for academic programs began. So, as the APEX process moved from administrative areas like human resources into clinical areas, “the wheels started coming off.” The attempt to close the Hershey clinical microbiology lab was emblematic of the confused decision making throughout the organization. PSGHS operated two microbiology labs: one in Hershey and one in Danville. To the business officers, the Hershey unit seemed the perfect target for consolidation. As one noted, “Because there was more volume and technical expertise, it made sense to do this in Danville.” The Danville lab processed two or three times the volumes as Hershey. Hershey physicians and scientists saw it differently; to them, the lab was an important and nonnegotiable component of residency training. So, they argued, the decision to close or move the Hershey microbiology lab was not simply a clinical decision to be made by PSGHS but involved the College of Medicine—its closure was a threat to the academic and institutional integrity of Penn State University. This dispute was not resolved before the merger was dissolved.

**Disagreement about the process to select new leadership**

As tensions mounted in the system, the senior leadership team encountered significant internal disagreement. A board committee recommended that the CEO and president both be replaced with a new leader, an idea that the board embraced. On September 20, 1999, both the CEO and the president announced plans to retire within a year. However, the divided board could not agree on the process for the search and structure of the position. Penn State board members insisted that the new CEO have 25% responsibility to the medical school with a direct reporting line to the president of Penn State; for the remaining 75%, the new CEO would report to the PSGHS board. Structured this way, the Penn State president, who had joined the board in June 1999, would have had final approval of the new position because the individual would serve as dean of a Penn State College of Medicine in addition to CEO of the health system. But as one participant said, “The leadership from the Geisinger side looked at that as not being an equal partner. They saw it as creating a partner that had power over the other in a merger that was supposed to be of equals. The board could never agree on a search process.” Despite agreement that new leadership was necessary, the board remained at odds over the selection process.

As these various difficulties began to compound, the merger unraveled. Unable to agree on a process to select a new chief executive, faced with financial impediments, and suffering from organizational dysfunction, the board voted to dissolve the merger on November 18, 1999, 28 months after it began. The de-merger took effect July 1, 2000.

**Reasons for the Dissolution of PSGHS**

Many factors contributed to the dissolution of PSGHS. As noted by key players from both organizations, however, three interrelated issues had a major impact on the tumultuous history and eventual collapse of the Penn State Geisinger Health System: (1) dysfunctional leadership, (2) distrust among board members, and (3) different organizational cultures. I will examine each in turn.

**Executive leadership**

Both the strategic direction and day-to-day operations of a large organization depend on the skill, vision, and team ability of the senior executives. Everyone interviewed for this case study—even the leaders themselves—agreed that the leadership team contributed to the failure of the merger. “They each served as lightning rods for dissent from the other side of the organization,” one interviewee agreed. They could not work together, did not build a common organizational culture and decision making tradition, and never agreed on authority and responsibility for various clinical and academic components of the system, all of which contributed to the dysfunction of the merged health system. Said one executive, “I think the personalities were the biggest problem.”

Both leaders were strong personalities who were used to running their respective organizations. After the merger, their abilities to compromise and defer to each other were tested. “The two CEOs thought that they could work together but they could not,” said a participant. Shouting matches and other unprofessional behavior were common.

Neither leader was accepted by the other campus. Geisinger physicians resented the president and chief academic officer,
who threatened the autonomy of their residency programs. Hershey clinical leaders and faculty didn’t trust the CEO. Underlying that lack of trust was the presumption of academic superiority; questioning of his academic credentials, curriculum vitae, and understanding of the academic environment.

**Board leadership**

The purpose of a governing board of a nonprofit organization is to foster an institution through strategic guidance and support so that the organization can fulfill its mission. Because of partisan posturing, however, the PSGHS board was unable to fulfill its core responsibility. Many of the problems that arose with the merger—financial, cultural, personnel related—were secondary to the failure of board cohesiveness, leadership, and direction. Chait, Holland, and Taylor identified six competencies of effective governing boards:

- **Analytical dimension.** The board recognizes the complexities and subtleties of issues and accepts ambiguity and uncertainty as healthy preconditions for critical discussion.

- **Political dimension.** The board accepts as a primary responsibility the need to develop and maintain healthy relationships among major constituencies.

- **Strategic dimension.** The board helps the institution envision a direction and shape a strategy.

Participants in the merger indicated that the PSGHS board failed to meet many of these competencies. For example, the board—evenly divided with Geisinger and Penn State nominees—did not develop a cohesive identity for itself. One board member without a previous affiliation described the situation:

> There was never a board retreat to create a common vision for the entity, to really grab hold of the organization, or to just get to know the other people. It became obvious from the start that a lot of [board members] perceived this as business as usual with a new name. It did not feel right from the beginning. The Geisinger people felt comfortable only with themselves and the Penn State trustees felt comfortable only with themselves... My perception from the very beginning was that the Geisinger people were there to protect the Abigail Geisinger Trust and the Penn State people were there to protect the College of Medicine. I never got the feeling anyone else was interested in taking all the assets and putting them together and starting from scratch.

Without a common board vision, the majority of its members resorted to their original loyalties to Penn State or Geisinger rather than the new institution. Because of the board governance structure, many votes were evenly split, with the board chairman breaking the tie with his extra vote. Perception problems abounded among board members. Penn State viewed the Geisinger members as local business leaders without an appreciation of the complex culture of an academic health center. Geisinger board members perceived that Penn State was attempting to wrest control of the organization; by compromising, they thought they would be caving to the power of the state.

**Organizational culture**

At the time of the merger, leaders cited a similar organizational culture as evidence of the goodness of fit between Penn State and Geisinger: both were nonprofit, physician-led groups with missions of patient care, education, and research and with common philanthropic histories. Paradoxically, many interviewees cited an incompatibility of organizational cultures as a reason for the dissolution of the merger. Was culture a pull or a push?

Those involved with the merger failed to understand the different layers of culture in organizations. Schein posited three layers of organizational culture: artifacts, espoused values, and underlying assumptions (see Figure 3). Artifacts are the observable products, activities, and behaviors of a group—easy to see but difficult to understand. Both Penn State and Geisinger had mission statements that emphasized patient care, education, and research. But did similarly worded mission statements suggest that the two organizations emphasized those three mission areas in the same way? The answer is, clearly, no. As Schein writes, "The observer... cannot reconstruct from [artifacts] alone what those things mean in the given group, or whether they even reflect important underlying assumptions." The commonality in mission existed only at the most superficial level of organizational culture. By the end of the merger, it was clear that the two groups viewed each other as betraying a common mission when, in fact, the prioritization of the mission
The Geisinger people thought that Penn State wanted to just take the money and run. Penn State people thought that Geisinger wanted to decimate the teaching ability of the medical school in order to create a positive cash flow within the clinical practices.46

What was lost [in the merger discussions] was the nuance of a classic group practice with 90% practice of patient care and a more traditional academic health center with a 50% focus on patient care; 35–40% on teaching and the rest on research.37

Espoused values, the next layer of organizational culture in Schein’s taxonomy, are stated beliefs about what is good and right in a group. But espoused values only predict “what people will say in a variety of situations but which may be out of line with what they will actually do in situations where those values, should, in fact, be operating.”52 Both organizations, for example, claimed to value participatory management. Both asserted that, as nonprofit organizations, they intrinsically shared common values. But, in practice, the traditions of operations and decision making at Penn State and Geisinger were quite divergent. To truly understand the cultures of the two groups and to predict their compatibility, leaders needed to explore a deeper level of organizational culture: basic underlying assumptions.

Underlying assumptions are the taken-for-granted beliefs that are rarely questioned, never debated, and nearly impossible to change. And as Schein asserts, “Any challenge to or questioning of a basic assumption will release anxiety and defensiveness.”52 These underlying assumptions are what truly guide behavior and can often be in conflict with espoused values. Penn State clinical chairs held an underlying assumption that entrepreneurial, independent decision making and questioning of authority were paramount; Geisinger chairs held an underlying assumption that cooperative interdependence placed the highest emphasis on patient care.53 These basic assumptions about their own culture led each group to view the other in a negative light: the Penn State chairs viewed Geisinger physicians as “rule-driven conformists who did not question authority”; Geisinger chairs considered Penn State faculty as “individualistic and careerist” who “put their publications before their patients.”53

It is possible for two organizations with different underlying assumptions to meld into one cohesive unit, but PSGHS did not have a vision for doing so. “There was never any feeling that this was a joint enterprise,” said one faculty member. “It was also a them-versus-us attitude.”59 Late in its history, the PSGHS board hired an organizational consultant to work with executives and physician leaders on a new cultural framework; the consultant facilitated discussions with the two departments of medicine to create a common culture. While physicians from the two campus agreed to a common vision, the progress ended when the merger was dissolved.47,53

Lessons Learned
Participants in this case study offered similar lessons about and advice on mergers in academic medicine. While case study research is not generalizable to a population, the Penn State-Geisinger case produces extrapolations2 that may be applicable to mergers in other settings and to large-scale institutional change in academic medicine and higher education.

New leadership and a plan for succession
Many participants in the process argued that new leadership was necessary to make the merger successful. as one said:

We made a mistake of keeping both CEOs. . . . It created tension between the two with groups of loyal subjects who supported their person and their person’s view and who were convinced that the person on the other side did not understand their problems. Dr. Evarts did not understand the Geisinger docs and their pressures and Dr. Heydt did not understand the Hershey docs. So how could he be our CEO?22

Many interviewees now believe that both leaders should have been offered an appropriate severance package and asked to retire.22,23,37 Then the board could have hired a new leader for the whole enterprise—someone with the credentials to garner the respect of the academic physicians in Hershey and with the business acumen to run a huge clinical enterprise. This suggestion begs the question whether the two leaders would have been interested in the merger if it meant they had to leave their posts.

Another participant offered an eloquent answer:

As leaders of an organization and stewards of its future, we have to come to grips with the fact that we are responsible for the organization, not for our personal interest. So if what is driving something is mainly your own ego—and I’m not saying it was, because I think everyone involved were people of good will—but if the driver is I want to merge because I want to be head of a nationally ranked Big Thing, then it should not get done. What’s needed is for everyone to understand that it is a new day. It is not Geisinger or Penn State; it is a new organization.37

The PSGHS board eventually came to the realization that the executive leadership needed to be replaced. A two-person board committee recommended that the CEO and president both step down and a search for a new CEO commence. But, as previously noted, the search process never got off the ground because it became mired in the distrust of one set of board members for the other. They could not agree to the terms for the new CEO position. This stumbling block, in turn, suggests another lesson learned. Not only should both leaders have been offered retirement, but a succession plan with a clearly defined description of the CEO position should have been developed in advance of the merger taking place.

Board structure
The board structure was designed for equal representatives from both Penn State and Geisinger. But this structure also allowed partisanship to grow. The board members maintained their loyalties to the original organizations rather than developing a new allegiance to the merged unit. The new board did not participate in board retreats, team building, or other types of strategies for forming a united vision for the new health system.23,48 Relationships became so poisonous that the two sides would caucus before board meetings and decide, as a group, how to approach the issue under discussion.40,46

The solution to this problem would have been to appoint fresh faces to the new organization’s board. Retaining a small number of board members from the two original organization would have ensured institutional memory. But the majority of directors should have been outsiders, agreed to collaboratively by both...
organizations. These new members could have come to the table without institutional baggage. The board also needed a well-defined succession plan for the chair so that it could have transitioned to new leadership without controversy.

Organizational due diligence

Interviewees who were involved in the initial premerger discussions asserted that the two organizations shared similar values, structure, history, and goals. They spent long, arduous hours negotiating the structure and governance of the new organization. But little attention was spent on an in-depth examination of the two organization’s cultures. One interviewee noted:

No one thought about the human side, the social side, of the merger. They weren’t trained to think about that. They only thought of the economics, about the money involved. But they didn’t consider the power of sense of identity and culture.57

Such problems suggest that, in addition to financial due diligence, organizations considering mergers or strategic partnerships ought to conduct organizational due diligence: an examination of the underlying beliefs and assumptions that drive decision making, leadership, governance, and operations. At a superficial level, Penn State and Geisinger appeared congruent in vision, mission, and governance. Such was not the case. Why didn’t leaders step back and examine these factors more closely? Several factors are at play. First, highly successful leaders think they can make a merger work, even when others have failed. Said one participant:

There are a lot of type A people here. They think they are right . . . They got so caught up saying, “This is the right thing to do.” Even though there were wheels falling off other health care mergers at the time, they thought, “This will not happen to us. We love each other.”31

Second, leaders got caught in the irrational exuberance of a big organizational transformation, ignoring warning signs or neglecting to answer tough questions. Leaders of both Geisinger and Penn State acknowledged that “you get caught up in the moment; you are really charged up”31 and “You get caught up in the moment; you get caught up in the euphoria.”24

Leaders need to examine a whole series of “What if?” questions. Skeptics need to be invited into the process—not with the goal of undermining it but to critically examine its foundations. Finally, negotiators need to think through what will happen if the merger dissolves. Who will be responsible for what? Organizations should consider a “prenuptial” agreement.

Involvement in a process of change

The negotiations between the two organizations occurred in total secrecy among a small number of people. When the announcement of the merger occurred, many individuals, some of considerable influence, were blindsided by the proposal. Rather than move forward with enthusiasm and momentum, leaders spent time and energy attempting to earn buy-in from important constituencies.

Secret negotiations are an affront, in particular, to the academic culture. Any institutional change must take into account the academy’s core values. “Given the structure and organization of higher education institutions and the centrality of academic values and purposes . . . it is not surprising that corporate models of change do not easily adapt to renewal efforts” in academe, write higher-education researchers Eckel and colleagues.54 They have noted that the corporate mentality of confidentiality in change processes creates problems in an academic culture:

Participatory decision making is an integral part of academic life. Although participation can slow the decision making process, a change effort will generally be more successful if many people with different perspectives contribute to its formulation and implementation. . . . A potential risk associated with broad participation is that the change agenda will become a weak compromise of interested parties. Negotiations and political tradeoffs may give everyone a little but not add to much. However, setting limits on participation has real costs and risks; it may cause the change effort to be embraced only by a minority, which, in turn, may cause its demise.34

The PSGHS merger needed the support and understanding of physicians and staff from both campuses to make it work. But because it was a closed process, involving a small number of individuals, that kind of support wasn’t achieved and, in fact, the secrecy engendered a loss of trust. Individuals from both organizations expressed similar views:

The discussions between Penn State and Geisinger were going on in secret, the model of the corporate world . . . But these weren’t corporations. They are complicated cultures. It has to be an open process.31

I think [the secrecy] was a mistake. If it becomes publicly exposed and you don’t have the answers for everything, then you get all kinds of noise in the system and you cannot work out the merger. But we never worked out the details, so we got noise in the system anyway. [The two organizations] needed some type of letter of intent that we would spend six months to see if we can create a model that everyone would buy in to.56

The problem with doing the discussion in secret is that both sides of the organization had a real lost of confidence in leadership. A loss of trust . . . But there was a sense that the deal could not be done if it had to be subjected to two-year discussions. One lesson for me is if you cannot stand up in a public meeting and talk about it and defend it, it is probably not worth doing.37

Some leaders argued, however, that the merger would never have occurred if it were an open process.23,24,28 At the very least, leaders must be mindful of the decision making norms and values of their individual organizations. In some settings, confidential negotiations are tolerated. Academic and professional settings are more likely to embrace a norm of wider participation. Additionally, leaders must consider the level of acceptance and support necessary to move the change initiative forward. In this case, many crucial physician leaders were not consulted. But in health care cultures, the process needs to be dialogic; physicians need to feel that they are being heard; they need to know why their ideas are taken or why they are not.42 One participant identified the need for this type of discussion:

In both places—Hershey and Geisinger—a great deal of progress gets made by planting seeds of thought in people’s minds. Had we used that time from June 1996 to January 1997 to get people accustomed to the idea, let them express their doubts and reservations, try to answer them, then—whether they fully agreed with it or not when it happened—at least they would have said, They asked me, they heard my concerns . . . As it was, the biggest response we got was, You
never asked me. I’ve worked here 20 years and you never asked me. What is going on?”

Aftermath

Upon the unwinding of the PSGHS merger, Penn State transferred $116.5 million to Geisinger in exchange for accounts receivable, equipment, inventory, and other assets.^55^ Penn State supplied a $150 million loan to Hershey Medical Center to cover these costs and supplied a $150 million loan to Hershey Medical Center to cover these costs and to provide working capital. Additional one-time costs for Penn State to dissolve the merger varied: figures ranged from $15–38 million.^22,^24,^56^ Despite those costs, Hershey Medical Center rebounded from the dissolution. For fiscal year (FY) 2001, the Medical Center posted a $1.58 million profit on $447.6 million in revenue. For FY02, the medical center had revenues of $493.5 million and a profit of $3 million. After several years of stagnancy, sponsored research funding increased 53% from 2000 to 2002, to $83 million. Geisinger also showed signs of improved financial performance. Its revenues grew from $955 million in FY2001 to $1.062 billion in FY2002, despite total losses in each year. Both organizations successfully recruited new leaders.

The university used the de-merger to form a separate nonprofit corporation for the Hershey Medical Center, allowing greater flexibility in operations and employment policies. In 2002, the Penn State College of Medicine still ranked 73rd of 74 state-supported medical schools in state funding, although it asked the legislature to increase the appropriation for medical education from $5 million to $35 million over the following three years.^24,^57^ With the dissolution of the merger, both organizations had “Dorothy” moments: renewed belief in core missions and values, the sense that “there is no place like home.” For Penn State, “in many ways the undoing of the merger set us on a path that has been very positive for us.”^40^ Leaders of the university, college of medicine, and academic medical center reaffirmed their commitment to the academic values that pervade their work settings. As one said, “The value system that exists within the academic health system is different than other kinds of health care enterprises; you have to be mindful of that.”^40^ Executives in the Geisinger Health System also professed similar epiphanies, focusing on core competencies and primary mission areas. According to one executive, “For Geisinger, the merger was a hard wake-up call that the path we were relying on—managed care with a small HMO—was not the right path. . . . But, for Geisinger, [the de-merger] was beneficial. It was painful, but it was beneficial.”^53^ Leaders concentrated on rebuilding specialty and subspecialty services and emphasized excellence in clinical care and insurance.^58^ Combining two large complex health care organizations into one does not necessarily produce economies of scale, organizational efficiencies, and an improved focus on patient care, education, and research. Without an exhaustive and in-depth review of organizational culture, mores, values, and mission, perhaps such alliances are, in fact, destined to be folly. As one participant said, “We aggravated a culture clash. We took two organizations and, in a short period of time, tried to force their cultures together. We slammed our culture smack into theirs.”^72^ Like ancient alchemists, the movers behind this merger tried to make “gold” from two separate structures, without a complete view and understanding of each substance, and with too much focus on outcome and not enough attention to process. Like alchemists, they embarked on a transformation strategy that, at the time and with the available information, was an accepted solution to a complicated problem. Like alchemists, they tried to create a structure of greater value and prestige. And like alchemists of old, they did not succeed in their attempt to “slam” two forms into one. But in their failure to find a grander form, they rediscovered and reaffirmed the true nature of their base.

This article was originally published in the November 2003 issue of Academic Medicine.

References
21. Medical School Profile System [database online] (http://www.aamc.org/data/msps/)

Academic Medicine, Management Series: Strategic Alliances in Academic Medicine
22 Zolko WW. Associate vice president for finance and business and controller, Penn State University College of Medicine. Personal interview with author, Hershey, Pa., 17 September 2002.

23 Evarts CM. Former senior vice president for health affairs and dean, Penn State College of Medicine; former president, Penn State Geisinger Health System. Personal interview with author, Hershey, Pa., 17 September 2002.

24 Schultz GC. Senior vice president for finance and business, Pennsylvania State University. Personal interview with author, University Park, Pa., 19 September 2002.


28 Heydt S. Former chief executive officer, Geisinger Health System; former CEO, Penn State Geisinger Health System. Personal interview with author. Hershey, Pa., 16 September 2002.


31 Trembulak F. Chief operating officer, Geisinger Health System; former chief operating officer, Penn State Geisinger Health System. Personal interview with author, Danville, Pa., 18 September 2002.


33 Zolko WW associate vice president for finance and business, Penn State University College of Medicine [unpublished data]. Provided to author 17 September 2002.


36 Geisinger Health System. Unpublished data provided to the author by F. Trembulak, chief operating officer, Geisinger Health System; former chief operating officer, Penn State Geisinger Health System. 18 September 2002.

37 Hamory B. Chief medical officer, Geisinger Health System; former chief medical officer, Penn State Geisinger Health System; former executive director of University hospitals and chief operating officer, Hershey Medical Center. Personal interview with author, Danville, Pa., 18 September 2002.

38 Deaver EA. Current board member, Geisinger Health System; former board member, Penn State Geisinger Health System. Telephone interview with author, 18 September 2002.

39 Norgen R. Professor of behavioral sciences, Penn State University College of Medicine. Personal interview with author, Hershey, Pa., 17 September 2002.

40 Spanier GB. President, Pennsylvania State University. Personal interview with author, University Park, Pa., 19 September 2002.


45 Goldman JN. Professor of medicine, Penn State University College of Medicine, Hershey Medical Center. Personal interview with author, Hershey, Pa., 17 September 2002.

46 Alexander W. Current board member, Geisinger Health System; former board member, Penn State Geisinger Health System. Personal interview with author, Hershey, Pa., 16 September 2002.

47 Maccoby M. President, The Maccoby Group; consultant to the PSGHS board of directors. Personal interview with author, Washington, DC, 19 August 2002.


58 Steele GD. President and chief operating officer, Geisinger Health System. Telephone interview with author, 14 January 2003.
Appendix

List of individuals who participated in case study interviews

William Alexander, current board member, Geisinger Health System; former board member, Penn State Geisinger Health System

Kevin Brennan, chief financial officer, Geisinger Health System; former chief financial officer, Penn State Geisinger Health System

Roger J. Bulger, MD, president, Association of Academic Health Centers; former board member, Penn State Geisinger Health System

E. Allen Deaver, current board member, geisinger health system; former board member, penn state geisinger health system

C. MacCollister Evarts, MD, former senior vice president for health affairs and dean, Penn State College of Medicine; former president, Penn State Geisinger Health System

John N. Goldman, MD, professor of medicine, penn state university college of medicine, hershey medical center

Bruce Hamory, MD, chief medical officer, Geisinger Health System; former chief medical officer, Penn State Geisinger Health System; former executive director of University hospitals and chief operating officer, Hershey Medical Center

Frank Henry, chairman of the board of directors, Geisinger Health System; former chairman of the board of directors, Penn State Geisinger Health System

Stuart Heydt, MD, former Chief Executive Officer, Geisinger Health System; former CEO, Penn State Geisinger Health System

Edward P. Junker, board member, Pennsylvania State University; board member, Milton S. Hershey Medical Center; former board member, Penn State Geisinger Health System

Darrell G. Kirch, MD, senior vice president for health affairs/dean, Penn State College of Medicine and chief executive officer, Hershey Medical Center

Michael Maccoby, PhD, president, the maccoby group; consultant to the psghs board of directors

Ralph Norgren, PhD, professor of behavioral sciences, Penn State University College of Medicine

Gary C. Schultz, senior vice president for finance and business, pennsylvania state university

Graham B. Spanier, PhD, president, pennsylvania state university

Glenn D. Steele Jr., MD, PhD, president and chief operating officer, geisinger health system

Frank Trembulak, chief operating officer, Geisinger Health System; former chief operating officer, Penn State Geisinger Health System

Wayne W. Zolko, associate vice president for finance and business, penn state university college of medicine