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Addressing the Root Causes of Parent–Subsidiary Dysfunction

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Matters of distrust, disagreement, discord, and other forms of dysfunction between the health system parent and its primary subsidiaries can threaten the strength and sustainability of the system, if not forcefully addressed. The ability to prevent such dysfunction depends on many factors, the most fundamental of which may be an understanding of the historical root causes of system dysfunction.

With the extraordinary consolidation of the inpatient healthcare sector, the vast majority of hospitals are operated as corporate affiliates of regional, interstate, or large national health systems. (This is particularly the case with non-profit providers.) Many of these systems were developed and have grown through acquisition, membership substitution, merger, or other forms of affiliation. The essence of these corporate relationships is that the hospital, foundation, and/or other major entity is controlled by the health system parent corporation through any one of a number of legally appropriate control mechanisms.

The potential for dysfunction arises when material disagreement occurs between the leadership of the parent and the leadership and related constituencies (e.g., community, donors, medical staff) of the subsidiary as to the purpose, intent, and binding terms of the legal and programmatic relationship. This, notwithstanding the fact that the substance of the relationship is likely the subject of binding legal agreements that were heavily negotiated in good faith.

"Triggers" of Dysfunction

Acute dysfunction can lead to legal and operational conflict, manifested through public dispute, governance discord, missed corporate opportunities, possible fiduciary breaches, and legal confrontation. At its most extreme, such dysfunction can threaten the long-term sustainability of the health system. Examples of "triggers" of dysfunction can include:

- **Culture**: The most subjective of factors can often serve as the most obvious expressions of conflict. "They're not like us"; "We don't share the same values"; "They just do things differently." Clashes of culture can manifest themselves broadly (e.g., in problem resolution, risk tolerance, executive evaluation, decision making, and the board–management dynamic.
- **Perpetual legacies**: The inability to successfully integrate business organizations, their leadership, and their strategic goals following an affiliation can be a "ticking time bomb." The proliferation of "legacy" or similar constituent interests can be toxic to an organization and its ability to come together as a cohesive, united enterprise. Legacy relationships can in some situations distort reasonable lines of corporate authority and frustrate the achievement of legitimate system goals.
- **Lack of detail**: Brevity has its virtues, except perhaps when it comes to memorializing the terms and conditions of a definitive transaction agreement. "Kicking the can down" rarely works in the negotiation process, as there is often little appetite or incentive to address tough issues post-closing. The failure or unwillingness to address the details of sensitive yet important provisions can leave the parties without any form of guide on "how things are to work" on key post-closing organizational matters. That creates a void in which dysfunction can flourish.
- **Leadership losses**: The departure from the system of key affiliation executive and board leaders can create a major gap in institutional knowledge of the rationale for the relationship and the related goals and expectations of the parties. The failure to "institutionalize"

such knowledge can rob the health system of a historical perspective when disagreement subsequently arises.

- **Change in focus**: A change in the health system's strategic direction, particularly as it affects the subsidiary, can often prove a lightning rod for subsidiary discontent, particularly if it was not well explained in advance and if it results in a significant change in the level of programs or services provided by the subsidiary.
- **Unclear duties**: One of the most common of all causes of discontent is a basic lack of understanding by the subsidiary board of its duties and authorities. It is axiomatic that health systems will seek to centralize authority and streamline decision making across all boards in the network. Such centralization may be essential to achieving efficiencies and eliminating redundancy in governance. While in most situations this leaves the subsidiary with important, if limited powers, the failure to clarify this—and the related benefits of the arrangement—can lead to significant discontent.
- **Capital misdirection**: Increasingly, the "consideration" provided to a hospital to join a larger system is the promise of access to capital, usually manifested through capital commitments contained in the definitive transaction agreement. Yet these commitments are often premised on meeting specific system capital budget approval processes. The failure of particular subsidiary capital initiatives to satisfy such processes can create controversy at the subsidiary level.

There are certainly other examples of dysfunction triggers. Yet they all seem to be based on a fundamental misunderstanding, an original failure to achieve a meeting of the minds during the negotiation process, lack of intra-system communication, or the lack of an established intra-system process for resolving leadership disputes.

Additional Causes and Considerations for Parent–Subsidiary Dysfunction

Of course, there are more objective factors that apply in dysfunctional situations, which can often work to support the purposes and legal interests of the parent company. These include the presence of a system-wide, uniform charitable purposes clause; the terms of the original definitive affiliation agreement; clear provisions in articles of incorporation and bylaws; and membership rights under state law. Such provisions are often used to support system cohesiveness and uniformity in decision making.

Yet, the situation can become complicated if state law impresses fiduciary obligations on the parent to support the interests of the subsidiary; if unique geographic service area, religious sponsorship, or community interest based provisions in the purposes clause of the articles of incorporation of the subsidiary—or similar unique rights or powers—are present in legal documents. Fortunately, only a handful of state courts recognize such a duty.

Parent–subsidiary dysfunction represents a high form of frictional cost. If not thoughtfully addressed at its incipiency, it can evolve to levels of extraordinarily costly contention, which can overshadow the reputations of the organizations and individuals involved and frustrate the achievement of their underlying healthcare mission. In extreme situations, it can also prompt the involvement of the state attorney general, acting to protect the underlying charitable assets.

Ultimately, no "silver bullet" exists to resolve instances of dysfunction, especially when some or more of the parties have difficulty engaging in good faith discussions. Yet an awareness of the traditional root causes of dysfunction can help parties be proactive in their attempt to defuse a potentially incendiary situation.

The Governance Institute thanks Michael W. Peregrine, Partner, McDermott Will & Emery, for contributing this article. His views do not necessarily reflect the views of McDermott Will & Emery or its clients. He can be reached at mperegrine@mwe.com.

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