

Making the most of multiple worlds: Multiple organizational identities as resources in the formation of an integrated health care delivery system

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**MAKING THE MOST OF MULTIPLE WORLDS:
MULTIPLE ORGANIZATIONAL IDENTITIES AS RESOURCES IN THE
FORMATION OF AN INTEGRATED HEALTH CARE DELIVERY SYSTEM**

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DEDICATION

This dissertation is dedicated to
my mother and
my first teacher,

Barbara Creary.

Thank you for planting these seeds
by always encouraging me to
“Go look it up.”
Rest in Paradise, Beautiful Lady.
I Love You.

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ABSTRACT

In spite of an undeniably vast and multidisciplinary body of research on mergers and acquisitions (M&As) spanning more than 50 years, extant scholarship provides little insight into how two organizations that have struggled to integrate *rebound* from failure in their relationship. This dissertation examines two organizations—AMC Hospital and Community Hospital—that achieved this outcome nearly 16 years after they legally merged. To understand this phenomenon, I conducted an inductive, longitudinal qualitative study of these two organizations and their members using interviews, archival data, and observations as my data sources and grounded theory techniques to analyze the data and build theory. Extending prior research on M&As, multiple organizational identity management, and identities as resources in organizations, I advance the notion of multiple identity resourcing by examining how the negotiation of multiple organizational identities fostered greater resource sharing and generation during post-merger integration. Additionally, I elaborate prior research on meaning construction during strategic change by examining how managers' interpretations of the power and intimacy dynamics in the merger relationship influenced their strategizing, which affected organizational-level episodes of success and failure during the integration process. More broadly, I demonstrate how practices at both the level of the merger relationship and the level of strategy implementation enable successful performance during post-merger integration.

Keywords: multiple identities, identity resourcing, relationships, meaning construction, strategic change

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CHAPTER ONE: INTRODUCTION

MOTIVATION

How do organizations *rebound* from failure during post-merger integration? In spite of an undeniably vast and multidisciplinary body of research on mergers and acquisitions (M&As) spanning more than 50 years, extant scholarship provides little insight into this question. While it is clear from past research that some M&A relationships “succeed” while others “fail” post-merger, definitions of success and failure in the M&A literature vary considerably (Stahl et al., 2013). For instance, successful M&A performance is judged frequently according to financial or economic criteria; that is, the extent to which M&A activity results in substantial financial returns or economic gains constitutes success (Almor, Tarba, & Benjamini, 2009; Angwin & Meadows, 2009; Chatterjee, Lubatkin, Schweiger, & Weber, 1992; Gomes, Angwin, Weber, & Yedidia Tarba, 2013; Haspeslagh & Jemison, 1991). As a result, critical success factors during the post-merger integration phase are often cited as those that can have a direct effect on financial performance, such as the integration strategy, leadership, speed of implementation, post-merger integration team activities, communication during implementation, managing corporate and national cultural differences, and human resource management (Gomes et al., 2013).

Yet, alternative perspectives suggest that more subjective performance indicators such as “synergy realization” (Larsson & Finkelstein, 1999) and managers’ and experts’ subjective assessments (Schoenberg, 2006) of M&A performance that focus on more proximal measures of efficiency gains as more appropriate measures of M&A performance. Namely, scholars argue that these measures can better account for the role of organizational and human resource issues that also contribute to M&A success or failure, yet are often unaccounted for the broader

strategic management literature (Larsson & Finkelstein, 1999). In this respect, Larsson and Finkelstein's (1999: 3) definition of synergy realization as "the actual net benefits...created by the interaction of two firms involved in a merger or acquisition" is one example of a measure that tries to capture the multitude of factors that affect M&A performance. For example, synergy realization can include new market access, the transfer of current know-how and the creation of new know-how.

Whether performance is defined by financial measures such as stock market performance, economic indicators such as economies of scale, or subjective measures such as synergy realization, extant research tends to view M&A performance as a dichotomous variable, that is, as a phenomenon that entails *either* success *or* failure but not elements of both (Almor et al., 2009; King, Dalton, Daily, & Covin, 2004). As a result, scholars lack insight into situations in which M&A performance has varied over time, for example, where firms with early integration "victories" fail to achieve substantial integration over the long-term or firms that attain limited synergy early on attain greater synergy over time. I propose that there are at least three reasons for this oversight. First, much of the research on M&A performance focuses on short-term gains as opposed to longer-term performance (Gomes et al., 2013). As such, limited insights into the longer-term time horizon may be yielding a somewhat inaccurate or premature verdict on M&A performance that does not account for the complete picture of what actually transpires over time. In other words, I suggest that much of the research yields a *snapshot* versus *panoramic* view of M&A performance. The strategy process view of M&As does address a longer-term time horizon but it frequently accounts solely for the process that leads to success *or* failure but not how episodes of success and failure emerge over time (Cartwright & Cooper, 1997; Haspeslagh & Jemison, 1991; Van de Ven & Poole, 2005).

A second reason for our lack of insight into changes in M&A performance is also related to our incomplete understanding of how post-merger integration processes unfold. Namely, much of the research on post-merger integration processes attributes success to the deliberate/planned nature of post-merger integration strategies without accounting also for their emergent properties. A view of post-merger integration processes and strategies as *also* emergent would reinforce existing research that positions strategy as a continuum of deliberate and emergent processes and “success” (and likewise, “failure”) as possible at many different points in time (Mintzberg & Waters, 1985). If post-merger integration strategies and processes were to be viewed in terms of both deliberate *and* emergent patterns, then our understanding of how these strategic patterns influence post-merger integration performance could be enriched as well. However, acknowledgment of the interaction between strategic patterns and post-merger integration performance is currently under-recognized in the M&A literature.

A third reason for our limited understanding of changes in M&A performance is that performance is frequently constructed as an aggregated firm-level outcome or dependent variable rather than in terms of its enactment or “what people do” at the group- or individual level. An increasingly widespread body of work in the management literature labeled Strategy-as-Practice (SAP) adopts a perspective that can enrich our understanding of post-merger integration performance as an individual-level phenomenon. Specifically, SAP research focuses on the practices, activities (i.e., praxis), and practitioners that affect both the process and the outcomes of strategy-making (Jarzabkowski, 2003, 2005; Jarzabkowski & Seidl, 2008; Vaara & Whittington, 2012; Whittington, 1996, 2006, 2007). As such, SAP research is concerned with human action and interaction and how strategy emerges from the interactions between practitioners and their social contexts, namely, the micro-level social activities, processes, and

practices that characterize organization strategy and strategizing. SAP research overlaps with classical Strategy Process research in terms of a shared interest in the activities of strategizing. Yet, SAP research differs from Strategy Process research in that the former focuses on strategizing as it unfolds at the micro-level while the latter is increasingly viewing strategizing as also a collective practice of organization, institution, and markets (Nicolini, 2009; Seidl & Whittington, 2014).

My research joins this growing body of SAP research to reveal the actions and experiences of individuals and groups involved in performing post-merger integration strategizing. It also accounts for both the deliberate and emergent nature of strategy work and how it affects organizations over time. As I am also interested in the strategy-performance nexus, I examine how strategizing contributes to organizational-level episodes of success and failure and differences in how individual practitioners perform strategy during a long-term post-merger integration process. As such, I contribute to existing SAP research by elaborating practices at the strategy-performance nexus. Further, I contribute to SAP research by linking identity dynamics at multiple levels of analysis to strategy-performance dynamics suggesting that micro-level understandings of “who we are” and “who I am” have a substantial impact on “what we/I do” and “how we/I perform strategy”.

Below, I introduce my core research questions and provide an overview of the dissertation and a brief summary of my empirical chapters.

CORE RESEARCH QUESTIONS

The initial purpose of this dissertation was to understand how multiple identities are used to create value in organizations during post-merger integration. Yet, common to inductive qualitative research, my research questions and theoretical framing became refined over time as I

became more familiar with the case and fine-tuned my data collection and analysis (Charmaz, 2006). Hence, my refined research question is, “*How do organizations rebound from failure during post-merger integration?*” The sub-questions aligned with this refined research question are: (1) *How do managers in two organizations that have struggled to integrate manage the tension between identity-based ‘unity’ and ‘distinctiveness’? How does managing this tension affect post-merger integration performance?* (2) *How do managers’ interpretations of the merger relationship influence how they perform a post-merger integration strategy?*

I draw on multiple theoretical traditions to understand changes in post-merger integration performance and to build theory. Namely, to understand the tension between identity-based unity and distinctiveness and how it is managed (RQ1), I draw from research in the field of organizational studies interested in how multiple organizational identities are managed (Pratt & Foreman, 2000) and research interested in identity management dynamics in M&As more specifically (Gaertner & Dovidio, 2000; Langley et al., 2012). To understand how managing the tension between unity and distinctiveness (i.e., the approach to managing multiple organizational identities) affects post-merger integration performance (RQ1), I draw on insights from an emerging resource-based perspective on identity in organizations (Caza & Wilson, 2009; Creary, 2015; Creary, Caza, & Roberts, 2015; Dutton, Roberts, & Bednar, 2010; Ely & Thomas, 2001) and strategy-as-practice research (Jarzabkowski, Balogun, & Seidl, 2007; Jarzabkowski & Kaplan, 2015; Vaara & Whittington, 2012). Further, to understand how managers’ interpretations of the merger relationship influence how they perform a post-merger integration strategy (RQ2), I draw on research on meaning construction during strategic change (Dutton & Dukerich, 1991; Gioia & Chittipeddi, 1991; Gioia & Thomas, 1996; Sonenshein & Dholakia, 2012), which also includes research that takes a strategy-as-practice perspective (Balogun &

Johnson, 2004, 2005; Rouleau, 2005; Rouleau & Balogun, 2011), and research on individual level responses to multiple organizational identities (Gaertner & Dovidio, 2000; Pratt & Corley, 2007; Pratt & Foreman, 2000; van Knippenberg, van Knippenberg, Monden, & Lima, 2002). Taken together, these research questions guide my empirical study of the links among strategizing, identity, and performance at multiple levels of analysis.

ORGANIZATION OF THE DISSERTATION

This dissertation is composed of six chapters. In Chapter Two, I provide the theoretical foundations for this dissertation, reviewing three bodies of literature that allow me to establish links among strategizing, identity, and performance: strategy-as-practice; managing multiple identities in organizational studies; and identities as resources in organizations. In Chapter Three, I reveal my methodology, detailing the research setting, sampling strategy and data collection techniques, and analytical techniques that I use to build theory in the remainder of the dissertation. Specifically, I use inductive, qualitative techniques to investigate strategizing, identity, and performance in two teaching hospitals “Community” and “AMC” (both pseudonyms) during a particularly protracted post-merger integration (between 1998 and 2014) that was intended to form a new, innovative and integrated health care delivery system. I began my field work in 2013 shortly after Community’s name had been changed to “AMC’s Community Hospital” and AMC and Community’s parent company had been renamed, “AMC Healthcare”.

In Chapter Four, I examine the processes and practices through which managers at AMC and Community collectively manage the tension between identity-based unity and distinctiveness over a 15-year period. I reveal how negotiating organizational identity including changing organizational names was critical to increasing post-merger synergy (i.e., consolidation and

standardization of processes and programs and utilization of excess capacity). I refer to this entire process which includes synergy realization as multiple identity resourcing. Overall, my theoretical story suggests how emergent dialogue about identity and emergent practices focused on identity management as a collective were successful in fostering greater resource sharing and generation.

In Chapter Five, I reveal a relational and recursive model of meaning construction during strategic that highlights the importance of managers' sensemaking about the merger relationship. Specifically, I reveal how a new integration strategy affected senior, middle, and front-line managers' interpretations of the power and intimacy dynamics in the relationship, how they managed the multiple organizational identities in the relationship, and how they related to one another during strategic change as a consequence. I then reveal how these dynamics motivated modification of the new strategy, which continued to affect managers' interpretations of the relational dynamics, management of multiple organizational identities, and relational activities as well. Overall, I propose that managers' own sensemaking about the merger relationship affects how they perform a new integration strategy as well as the characteristics of the strategy itself.

Finally, Chapter Six synthesizes the findings from my dissertation by providing observations across empirical chapters, summarizes the theoretical and practical implications, and offers concluding comments and reflections.

CHAPTER TWO: THEORETICAL FOUNDATIONS

The purpose of this dissertation is to build theory on how organizations rebound from failure during post-merger integration. Specifically, I am interested in examining the processes and activities through which this occurs. As described in the introduction, this research is targeted around one primary question and several sub-questions. While these sub-questions are broad, they are intended to reflect possible directions that might become important in investigating the larger research question in the field. My intention in this theoretical chapter is to orient the reader to the major theoretical perspectives upon which this dissertation is based and that serve as background for answering the both the primary and sub-research questions. Specifically, I work with insights from strategy-as-practice research, research on managing multiple identities in the field of organizational studies, and research on identities as resources in order to articulate how investigating these questions can help us build or extend theory on post-merger integration.

STRATEGY-AS-PRACTICE

Past research on strategic management has relied primarily on economic analyses of the firm in order to capture a wide range of factors at the individual, organizational, and societal/macro-institutional levels that shape firm performance. In more recent years, however, organizational scholars have turned increasingly toward social theories to advance knowledge in the field of strategic management and to understand strategy not just as something a firm “has” but as something that people “do” (Jarzabkowski, 2003, 2005; Jarzabkowski & Seidl, 2008; Vaara & Whittington, 2012; Whittington, 1996, 2006, 2007). This focus on “doing” or “strategy-making/strategizing” has provided new insights into the practices, the work, and the role and identity of individuals involved in strategic management. Frequently, this research is categorized under the label Strategy-As-Practice (SAP) (Vaara & Whittington, 2012).

Scholars characterize SAP research as concerned with “what people do in relation to strategy and how this is influenced by and influences their organizational and institutional context” (Johnson, Langley, Melin, & Whittington, 2007: 7). SAP research differs from traditional strategy research in that it broadens the scope of what strategy research explains beyond economic performance. It also enriches traditional strategy research in that it draws directly on practice-based studies in social theory (Heidegger, 1962; Wittgenstein, 1951) and in the social sciences more broadly (Reckwitz, 2002; Rouse, 2007; Schatzki, Knorr-Cetina, & von Savigny, 2001) to explain phenomena related to strategy-making (i.e., strategy formulation and implementation). Practice theory reveals how social structures and individual agency work together through social practices to influence action (Bourdieu, 1990; Foucault, 1977; Giddens, 1984; Schatzki et al., 2001). Furthermore, the “practice approach” includes analyses that “(1) develop an account of practices, either the field of practices or some subdomain thereof (e.g., science), or (2) treat the field of practices as the place to study the nature and transformation of their subject matter” (Schatzki, 2001: 2).

In SAP research, the interaction between structure and agency in strategy-making is revealed by examining practices (i.e., tools, norms, procedures of strategy work), praxis (i.e., activities such as strategic planning processes or meetings) and practitioners (i.e., strategists) involved in or that influence strategy-making (Jarzabkowski et al., 2007; Vaara & Whittington, 2012). One line of SAP research is interested in explaining the practices that enable and constrain strategy-making. Scholars adopting this view of practice emphasize the practices that shape stability and change in organizations and facilitate the work of strategists. These practices include but are not limited to the use of tools for strategy making (Jarratt & Stiles, 2010; Kaplan, 2011), strategic planning as a mediator of strategic change or continuity (Hendry, Kiel, &

Nicholson, 2010; Jarzabkowski, 2003), the effect of strategic meeting practices on strategic discussions (Jarzabkowski & Seidl, 2008), the role of discursive practices in constructing and legitimating strategy (Vaara, Kleymann, & Seristö, 2004), and the tools that can shape financial performance (Jarzabkowski & Kaplan, 2015).

A second line of SAP research is interested in explaining what goes on in episodes of strategy-making, namely the deliberate activities at the micro-level (i.e., praxis) that underlie many of the strategic management concepts often described at a much higher-level (Vaara & Whittington, 2012). From a praxis perspective, “practice” refers to the activities that managers engage in to accomplish the organization’s strategy work (Jarzabkowski, 2005). Scholars taking this activity-based view address “the detailed processes and practices which constitute the day-to-day activities of organizational life and which related to strategic outcomes” (Johnson, Melin, & Whittington, 2003: 3). For instance, Salvato (2003) identified the daily activities associated with the dynamic capabilities in two mid-sized firms. Balogun and Johnson (2005) showed how interactions between middle managers shaped the sensemaking around a strategic change. And Paroutis and Pettigrew (2007) identified seven different activities at different levels of the organization that make up the practices of strategy work. Ultimately, praxis accounts for the situated nature of activity, that is, activity that shapes and is shaped by the society within which it occurs (Jarzabkowski, 2003). As such, the interaction between macro and micro contexts is very important to understanding practice from an activity-based view of SAP.

A third line of SAP research is interested in explaining the role of practitioners in strategy-making, including the role of strategy teams (Paroutis & Pettigrew, 2007), strategy directors (Angwin, Paroutis, & Mitson, 2009), and middle managers as strategists (Mantere, 2005; Rouleau, 2005) in strategy formulation and implementation. To this end, SAP research

overlaps to some extent with the Process approach to strategic management, which focuses on how individual managers and teams make strategies and explains how individual- or team-level managerial processes affect organizational performance (Hernes & Maitlis, 2010; Tsoukas, 2010; Tsoukas & Chia, 2002).

To date, an SAP lens has been used to understand M&A activity in a limited way. Namely, some scholars focus on the discursive practices, often from a critical perspective, that help various audiences make sense of a merger and that are mobilized to legitimate or resist change (Vaara et al., 2004; Vaara & Monin, 2010; Vaara & Tienari, 2002, 2011). For example, Vaara and colleagues (2004) revealed the micro-level discursive practices that characterize strategizing in airline alliances and are used to make sense of airline alliances. As such, there is still considerable opportunity to develop a practice-based understanding of post-merger integration strategies.

MANAGING MULTIPLE IDENTITIES IN ORGANIZATIONAL STUDIES

In the context of M&As, scholars have described the identity dynamics that ensue between two organizations involved in a merger (Gaertner & Dovidio, 2000) as well as the ways in which organizational members respond to the multiple identities that are salient in a merger relationship (van Knippenberg et al., 2002; Van Knippenberg & Van Leeuwen, 2001; Van Leeuwen, van Knippenberg, & Ellemers, 2003). In this section, I review extant literature in organizational studies that is interested in understanding how multiple identities are managed at the individual- (Blader, 2007; Caza & Wilson, 2009; Creary et al., 2015; Deaux, 1991; Ramarajan, 2014; Roccas & Brewer, 2002; Rothbard & Ramarajan, 2009) and organizational-levels of analysis (Pratt & Foreman, 2000) in general and in the M& A context more specifically. In doing so, I lay important groundwork for understanding how the sense of “who I am” and

“who we are” affects and is affected by post-merger integration when there are multiple potential targets for identification and the tension between identity-based “unity” and “distinctiveness” is palpable.

Managing Multiple Individual Identities at Work

Insights from research on managing multiple individual identities at work are helpful for understanding how individuals conceive of themselves post-merger. Much of the research on managing multiple identities at work has focused on identities at the individual level of analysis (Blader, 2007; Caza & Wilson, 2009; Creary et al., 2015; Deaux, 1991; Ramarajan, 2014; Roccas & Brewer, 2002; Rothbard & Ramarajan, 2009). Identities at the individual-level have been described as the descriptive meanings that individuals use to define themselves that influence the ways in which they make sense of the social world and their place within it. Identities also influence how individuals act, interact within, and influence their environments (Mead, 1934; Stryker, 1980; Tajfel & Turner, 1979). In the work domain, multiple identities are sources of such meaning and action for individuals (Caza & Wilson, 2009; Creary et al., 2015; Dutton et al., 2010; Pratt & Kraatz, 2009). These identities include but are not limited to social identities tied to one’s organizational affiliation (Ashforth & Mael, 1989) or profession (Ibarra, 1999; Pratt, Rockmann, & Kaufmann, 2006), and managerial identities tied to one’s role in an organization (Sluss & Ashforth, 2007).

Research in organizational studies suggests that more than one individual-level identity can be salient at the same time at work or “coactivated” (Blader, 2007; Caza & Wilson, 2009; Creary et al., 2015; Deaux, 1991; Ramarajan, 2014; Roccas & Brewer, 2002; Rothbard & Ramarajan, 2009). Factors at both the organizational- and individual-level can foster coactivation. Namely, organizational pressures towards inclusion (Ramarajan, 2014) as well as individual

preferences or tolerance for simultaneity can promote coactivation (Ashforth & Johnson, 2001; Nippert-Eng, 1996). For example, Amway pressures distributors to transform friends and family members into co-workers and clients which can coactivate work and family identities (Pratt, 2000). In addition, individuals who prefer to integrate rather than segment their home and work identities are more likely to experience coactivation than those who do not (Nippert-Eng, 1996). As another example, a priest may choose to incorporate a former career as an actress into her priestly duties (Kreiner et al, 2006) or a female professional may incorporate a feminist identity into her work identity (Meyerson & Scully, 1995). Yet, while it is clear from the literature that coactivation is common, individuals experience coactivation in different ways. I review this perspective below.

The conflict perspective. We have some indication from the literature that some individuals experience identity coactivation as a negative phenomenon and that coactivation yields a sense of conflict for these individuals. This “conflict perspective” proposes that coactivation promotes identity conflict, drains psychological and physiological resources, and negatively affects psychological health (e.g., Frone, Russell, & Cooper, 1992; Gordon, Pruchno, Wilson-Genderson, Murphy, & Rose, 2012; Ladge, Clair, & Greenberg, 2012). When identities are perceived as being in conflict with one another, individuals are likely to enact only the identity that is considered most relevant to the situation.

The work-family literature, for instance, explores individuals’ experiences with the coactivation of work and family identities and the implications for their stress, well-being, and workplace outcomes (e.g., Frone et al., 1992; Gordon et al., 2012; Ladge et al., 2012). For example, engagement in both work and caregiving roles can increase the salience of work and caregiving identities and promote a sense of identity conflict in each role (Gordon et al., 2012).

Such identity conflict may lead to a drain of psychological and physiological resources, negatively affecting psychological health (i.e., role overload; Biddle, 1986; Greenhaus & Beutell, 1985; Rothbard, 2001). Research on gender and diversity at work also explores coactivation and conflict between work-related and nonwork-related identities (e.g., Bell, 1990; Ely, 1994). For instance, Ely (1994) found that some women attorneys in male-dominated firms perceived that their gender inhibited the performance of their professional identity. Finally, individuals can experience identity conflict between coactivated personal and occupational identities. Kreiner and colleagues (2006) found that, in some cases, individuals' overidentification with an occupational identity relative to their personal identity created the perception of perceived invasion of the personal identity by the occupational identity (Kreiner et al., 2006).

Identity conflict has implications for identity enactment. Identity enactment occurs whenever an individual engages in behaviors, activities, and routines that are consistent with an identity (Thatcher & Zhu, 2006; Thoits, 1983). An individual experiencing identity conflict may reorder his or her identities' importance such that he or she defers to and enacts only the most important identity (Ashforth, Harrison, & Corley, 2008) or the one that is considered more situationally-relevant (Ashforth & Johnson, 2001; Kreiner et al., 2006). For example, when identity conflict is experienced between work- and non-work related identities at one's job, individuals are more likely to enact work-related identities since these are typically more aligned with the performance of work-related tasks and activities. When identity conflict is experienced between two or more work-related identities, an individual may enact only the identity that respond to the needs of the moment. For instance, physician-managers may be torn between their loyalties to their patients and being validated as a "physician" and their commitment to economic matters and being validated as a "manager." As such, they may use the rhetoric of

patient care associated with their physician identities to build relationships and credibility when meeting with physicians who are not managers and the rhetoric of management associated with their managerial identities to build relationships and credibility when meeting with managers who are not physicians (Hoff, 1999).

The enrichment perspective. Other individuals may experience identity coactivation as a positive phenomenon such that multiple identities are experienced as compatible and synergistic at work. I refer to research concerned with this phenomenon as “the enrichment perspective.” One assumption behind this enrichment perspective is that individuals do not have fixed cognitive resources but instead have an expandable amount of emotional and psychological energy with which to manage their multiple identities (Dutton et al., 2010). Thus, it is in altering the perception that an individual has of the relationship among his or her multiple identities that is important to enacting multiple identities at work. For instance, individuals can achieve a state of optimal balance (Branscombe, Ellemers, Spears, & Doosje, 1999; Kreiner et al., 2006) and increased sense of harmony between different identities by viewing these identities as compatible (Dutton et al., 2010; Greenhaus & Powell, 2006; Rothbard & Ramarajan, 2009). This change in perception can lead to enhanced well-being, increase individual productivity, and improved interpersonal problem solving at work (Rothbard & Ramarajan, 2009).

Another assumption behind the enrichment perspective is that actually enacting multiple identities can mitigate stress and enhance individual well-being (i.e., Thoits, 1983). For instance, involvement in work and family roles can buffer individuals from distress in one of the roles (Voydanoff & Donnelly, 1999) can produce positive experiences and outcomes in the other role (Crouter, 1984; Ruderman, Ohlott, Panzer, & King, 2002). Bell (1990) found that while black professional women can find it difficult to manage the expectations, values, and roles in relation

to the black community and their work-related identities, their experiences as members of multiple social groups can contribute to their uniqueness and well-being. Caza and Wilson (2009) revealed that certified nurse midwives' identities as both nurses and midwives enabled them to utilize both natural health practices and more traditional medical interventions in their practice. As such, the enrichment perspective proposes that coactivation can promote individual well-being, increasing the number of resources that an individual has to draw upon in times of need (e.g., Dutton et al., 2010; Greenhaus & Powell, 2006; Rothbard & Ramarajan, 2009). To experience such positive outcomes, individuals must experience harmony or compatibility among the identities concerned.

Managing multiple identities at the individual-level in the M&A literature. The M&A literature frequently examines individuals' post-merger self-conceptions through the lens of "organizational identification." Organizational identification refers to "the perception of oneness with or belongingness to an organization, where the individual defines him or herself in terms of the organization(s) in which he or she is a member" (Mael & Ashforth, 1992: 104). It also accounts for the high value that an individual places on membership in an organization (Ashforth et al., 2008). The M&A literature acknowledges that individuals may potentially identify with multiple organizations post-merger: their pre-merger organization, the organization with which their organization is merging, and a superordinate/ "common" post-merger organization comprised of members from both pre-merger organizations. Much of the literature suggests that successful mergers transform perceptions from "us" and "them" to a more inclusive "we." As such, scholars propose that identifying with a superordinate or common postmerger organization and deidentifying (i.e., not defining oneself in terms of an organization) with a premerger organization is important for mitigating bias and competition during post-merger

integration (Gaertner & Dovidio, 2000). Yet, in some contexts, a “dual identity” representation in which both the premerger and superordinate post-merger identities are salient may be desirable for reducing threat, resistance, and intergroup bias (Gaertner & Dovidio, 2000; Gaertner et al., 2000). In many cases, however, individuals choose to identify with only a single organization. For example, individuals from a more powerful organization may choose to identify with only their pre-merger organization when merger partners are unequal in status and they feel that the merger threatens their status (van Knippenberg et al., 2002). Individuals may also choose to identify with only their pre-merger organization and not a post-merger organization when their organization is the less powerful partner in the merger relationship and their sense of continuity is at stake (van Knippenberg et al., 2002). However, individuals who are members of the more dominant organization in the relationship or those who feel that that keeping parts of their identification with their premerger organization is possible are more likely to identify with their pre-merger organization *and* a superordinate post-merger organization (Van Dick, Wagner, & Lemmer, 2004; Van Leeuwen et al., 2003).

While the M&A literature is clear about the psychological consequences of multiple identity management for individuals during post-merger integration (i.e., threat, resistance, and intergroup bias) and does suggest that differences in post-merger identification depends on whether people belong to a dominant or non-dominant organization in an M&A, it is unclear how these psychological consequences and behaviors affect strategy work among managers particularly during post-merger integration. For instance, we know little about how one’s identification with one or more organizations affects their strategy work in the present and in the future. We also know little about how one manager’s strategy work affects another manager’s sense of self and/or strategy work. As such, there is considerable opportunity to use insights

from research on managing multiple identities at the individual level to enrich research on post-merger integration.

Managing Multiple Organizational Identities

Much like research on managing multiple identities at the individual-level, research on managing multiple identities at the organizational-level suggests that multiple conceptualizations of an entity, in this case, the organization, can yield potential benefits as well as potential costs (Pratt & Foreman, 2000). Drawing on micro-level research, Pratt and Foreman (2000) proposed that, on the one hand, having multiple organizational identities within a single organization can allow an organization to meet the needs of different stakeholders. On the other hand, organizations with multiple organizational identities may have resource and coordination challenges in strategic decision-making and/or implementation as they attempt to be “all things to all people.” Bearing these different outcomes in mind, the authors organized a conceptual framework of four managerial responses to managing multiple organizational identities based on the desired level of plurality (maintaining vs. reducing multiplicity) and synergy (creating overlap or separation): compartmentalization, deletion, integration, and aggregation.

Compartmentalization responses preserve all identities in question but do not seek to attain any synergy among them. These responses are “appropriate when the support by powerful stakeholders for, the legitimacy of, and/or the strategic value of existing identities is high and/or resource constraints are low, and when the compatibility, interdependence, and/or diffusion of identities is low” (26). Deletion responses expunge one or more organizational identities with little concern for plurality or synergy. They are appropriate when “support by powerful stakeholders for, the legitimacy of, and/or the strategic value of existing identities is low and/or resource constraints are high and when the compatibility, interdependence, and/or diffusion of

the multiple identities is low” (29). Integration responses combine all identities into a distinct new whole aiming to reduce plurality while creating greater synergy. They are appropriate when “the support by powerful stakeholders for, the legitimacy of, and/or the strategic value of existing identities is low and/or resource constraints are high, and when the compatibility, interdependence, and/or diffusion of the identities is high” (30). Finally, aggregation responses retain all organizational identities and create links among them, aiming to create high synergy while maintaining high plurality. They are appropriate when “the support by powerful stakeholders for, the legitimacy of, and/or the strategic value of existing identities is high and/or resource constraints are low, and when the compatibility, interdependence, and/or diffusion of the identities is high” (32). Of the four, the authors suggested that the integration response most resembles what happens when two organizations merge and a new organizational identity emerges from the fusion of the two.

Managing multiple identities at the organizational-level in the M&A literature.

Taking a social identity theory approach (Tajfel & Turner, 1979; Tajfel, 1978; Turner, 1982), scholars have revealed how mergers can promote “us vs. them” dynamics that contribute to intergroup bias and conflict at the organizational level (Gaertner & Dovidio, 2000; Gaertner, Dovidio, Anastasio, Bachman, & Rust, 1993).¹ As a result, developing a “common ingroup identity” or recategorizing organizational identity from two organizations to a new post-merger organization can be important to merger success (e.g., Clark, Gioia, Ketchen, & Thomas, 2010; Gaertner & Dovidio, 2000). Yet, recategorizing organizational identities from two identities to

¹ Social identity theory proposes that individuals belong to multiple social categories or memberships (Tajfel & Turner, 1979; Turner, 1987). Each category or membership is represented in the self-concept as a social identity that both describes and prescribes how one should think, feel, and behave as a member of that group. Other members of those groups are typically defined as “us” while outsiders are typically defined as “them.” These “us vs. them” dynamics can be used to explain intergroup behavior.

one may exacerbate identity threat and resistance (Crisp, Stone, & Hall, 2006). In this respect, preserving the distinctiveness of two organizations in the context of a merger may be important for mitigating potentially negative outcomes, such as threat and resistance (cf., Crisp et al., 2006; Hogg & Terry, 2000).

Though not drawing on Pratt and Foreman's framework explicitly, a few studies have contributed insights on how multiple organizational identities are managed within the context of mergers. Notably, scholars have honed in on the problem of "identity ambiguity" before and after organizational mergers (Clark et al., 2010; Maguire & Phillips, 2008). For example, in a study of the merger of Citibank and Travelers, Maguire and Phillips (2008) found that in order to manage the challenges of "schizophrenia" (i.e., lack of clarity about whether to act together or separately) which included a loss of trust in the organization, the new post-merger organization, Citigroup, came to resemble the core, distinctive and enduring features of Travelers over time. Hence, the Citibank identity was "deleted" from the Citigroup organization. Similarly, Clark and colleagues (2010: 415) found that identity ambiguity was problematic in the planning of a merger between two hospitals and led to a state among executives described as "schizophrenic" and impeded collaboration. At the same time, executives from both organizations were concerned about relinquishing their organization's existing identity. As a result, a temporary and transitional identity was created as a representation of the future merged organization which led to greater collaboration from executives in both organizations (cf., "aggregation"; Pratt & Foreman, 2000).

Yet, research interested in how multiple organizational identities are managed in the M&A context has developed largely apart from research on managing multiple organizational identities in the broader organizational studies literature. While synergies between these two

literatures may exist, more work needs to be done to bridge these two literatures and broaden our understanding of the managerial practices that are used to manage multiple organizational identities during post-merger integration.

IDENTITIES AS RESOURCES IN ORGANIZATIONS

Understanding the ways in which multiple organizational identities are managed in the post-merger integration context is important for understanding how to solve identity-based strategic problems in organizations (e.g., integration failure). Yet, additional insights on the “value” of identities in organizational life are necessary for understanding the identity-performance link in organizations. Thus, in this section, I review an emerging resource-based perspective on identities in the organizational studies literature that helps us understand the value that identities at the individual-level hold in organizational settings (Caza & Wilson, 2009; Creary, 2015; Creary et al., 2015; Dutton et al., 2010; Ely & Thomas, 2001). Some of this research draws on theories of psychological well-being (e.g., Hobfoll, 1989; Thoits, 1983), while other research draws on the value-in-diversity hypothesis (Cox & Blake, 1991), and more sociological perspectives on resources in organizations (Baker & Faulkner, 1991; Eisenhardt & Martin, 2000; Feldman, 2004). In this respect, past research on identities at the individual-level as resources at work lays important groundwork for understanding the relationship between identity dynamics and performance in organizations.

Identities at the individual-level as a personal resource. Conservation of resources theory (COR) theory (Hobfoll, 1989) was proposed originally to bridge the gap between environmental perspectives on stress (e.g., Cannon, 1932; Selye, 1950) and cognitive perspectives on stress (e.g., Lazarus & Folkman, 1984).² Its basic tenet is that “...people strive

² Environmental perspectives on stress depict stress as a way of protecting the body from environmental challenges (e.g., Cannon, 1932; Selye, 1950). Cognitive perspectives on stress

to retain, protect, and build resources and...what is threatening to them is the potential or actual loss of these valued resources” (Hobfoll, 1989: 516). Personal resources, according to COR, are “those objects, personal characteristics, conditions, or energies that are valued by the individual or that serve as a means for attainment of these objects, personal characteristics, conditions, or energies” (Hobfoll, 1989: 516). Material objects, such as tools for work and a car, are resources when their physical nature, rarity, or expense makes them valuable. Conditions that are defined socially and culturally, such as supportive work relationships, status, tenure, and seniority, are resources to the extent they are favorable to an individual. Personal characteristics, such as one’s skills, self-esteem, and self-efficacy, are resources to the extent that they support a positive sense of self. Finally, energies, such as time, money, and knowledge, are resources to the extent that they aid the acquisition of other kinds of resources (e.g., employment contacts). Personal resources tend to aggregate in “resource caravans” (Hobfoll, 1989; Hobfoll, 2011) such that having one kind of resource is typically linked with having other kinds of resources (Hobfoll, 2001). For example, individuals with high self-esteem are more likely to have a better social support system than those with low self-esteem (Cozzarelli, 1993; Rini, Dunkel-Schetter, Wadhwa, & Sandman, 1999). Further, psychological stress ensues when personal resources are threatened with loss, when personal resources are actually lost, or when individuals fail to gain resources following resource investment. Therefore, when confronted with stress, individuals strive to minimize resource loss by investing other resources to offset actual or further loss. When not confronted with stress, however, individuals strive to use their existing resources to

depict stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her own resources and endangering his or her well-being” (Lazarus & Folkman, 1984: 515).

develop resource surpluses in order to offset the possibility of future resource loss (e.g., Hobfoll, 1989). Hence, resources are both reactively and proactively deployed.

Drawing on COR theory, organizational scholars have proposed that identities are personal resources at work (e.g., Caza & Wilson, 2009; Dutton et al, 2010). Caza and Wilson (2009) proposed that identities function as energy resources that are used to attain other resources at work. They found that identifying with multiple social groups simultaneously enabled certified nurse midwives to obtain social support from both nurses and midwives. In particular, certified nurse midwives had diverse social networks as a result of their multiple identities and, thus, were able to use their multiple memberships as sources of social support. Similarly, Dutton and colleagues (2010) proposed that positive identities at the individual-level can help individuals gain access to additional social resources at work. Positive identities include those identities that are infused with “virtuous qualities and character strengths”, viewed in “favorable regard”, “growing in content” over time, “aligned with internal and external standards”, and in a “balanced and/or complementary relationship” with one another (p. 290). Namely, positive identities enable individuals to increase the number, diversity, and quality of relationships that they have at work which can help them acquire other resources that strengthen them in stressful or challenging situations. As such and similar to the tenets of COR theory, an individual’s identities can function as resources that mitigate threats/demands and negative outcomes and/or enable an individual to accumulate other resources that promote individual well-being at work.

Dutton and colleagues (2010) also proposed that the number, quality, and diversity of interactions that individuals have with others at work impacts whether identities can create personal value for those individuals. For example, the authors suggest that an individual whose

identity is imbued with virtuous characteristics and acts benevolently toward others is more likely to develop higher quality interactions with others (Baker & Dutton, 2007). They also suggest that these higher quality interactions are more likely to promote individual and collective functioning at work. Further, individuals with multiple positive identities who engage frequently with a diverse group of otherwise unconnected people may possess a greater amount of social capital than those who do not. Such diversity in one's personal network can help individuals to access career opportunities and gain social support (Dutton et al., 2010).

Identities at the individual-level as an organizational resource. The field of organizational studies also suggests that the enactment of individual-level identities can affect organizational resources (Ely & Thomas, 2001; Fitzsimmons, 2013). Organizational resources are assets that can be used to implement value-creating strategies (Eisenhardt & Martin, 2000). For example, Ely and Thomas (2001) revealed how attorneys in a law firm enacted their racial identities to gain entrée into different markets and to effectively reconfigure their work processes. Specifically, they spent time exploring their different perspectives with other members of their work groups and determining how these perspectives should be used to make work groups more effective. Though not studied empirically, the authors posited that because the work groups' tasks were fundamentally connected to organizational goals (e.g., gaining entrée into previously inaccessible markets) that these diversity perspectives also had implications for organizational performance. In a conceptual paper, Fitzsimmons (2013) proposed that using the intercultural skills (i.e., adaptability, flexibility, interpreting cultural behaviors, negotiating across cultures) that multicultural employees have developed through their memberships in multiple cultural groups can help organizations solve complex global problems.

While this review focuses on individual-level identities as resources for individuals and their organizations, it is possible that organizational-level identities may play a similar role in organizational life. For example, managers may draw on elements of different organizational identities to create a new policy, procedure, or practice. However, further research is needed to understand how, if at all, organizational-level identities also affect performance at multiple levels of analysis in organizations.

CHAPTER SUMMARY

The intention of this chapter was to orient the reader to the major theoretical perspectives that underlie this dissertation and that serve as background for answering my research questions and building theory on how post-merger integration performance shifts over time. Each chapter integrates multiple theoretical perspectives including those I have reviewed in this chapter as well.

In Chapter Four, I answer the questions, “*How do managers in two organizations that have struggled to integrate manage the tension between identity-based ‘unity’ and ‘distinctiveness’? How does managing this tension affect post-merger integration performance?*” To understand the tension between identity-based unity and distinctiveness and how it is managed during post-merger integration, I draw from research in the field of organizational studies interested in how multiple organizational identities are managed (Pratt & Foreman, 2000) and research interested in identity management dynamics in M&As more specifically (Gaertner & Dovidio, 2000; Langley et al., 2012). And to understand how the management of the tension between unity and distinctiveness (i.e., the approach to managing multiple organizational identities) affects post-merger integration performance, I draw on insights from research on identities as resources in organizations (Caza & Wilson, 2009; Creary, 2015; Creary et al., 2015;

Dutton et al., 2010; Ely & Thomas, 2001) and strategy-as-practice research (Jarzabkowski et al., 2007; Jarzabkowski & Kaplan, 2015; Vaara & Whittington, 2012).

In Chapter Five, I answer the question, “*How do managers’ interpretations of a merger relationship influence how they perform a post-merger integration strategy?*” To understand this question, I draw on research on meaning construction during strategic change (Dutton & Dukerich, 1991; Gioia & Chittipeddi, 1991; Gioia & Thomas, 1996; Sonenshein & Dholakia, 2012) which includes research that takes a strategy-as-practice perspective (Balogun & Johnson, 2004, 2005; Rouleau, 2005; Rouleau & Balogun, 2011) and research on individual-level responses to multiple organizational identities (Gaertner & Dovidio, 2000; Pratt & Corley, 2007; Pratt & Foreman, 2000; van Knippenberg et al., 2002).

Taken together, these research questions guide my empirical study of the links among strategizing, identity, and performance at multiple levels of analysis.

CHAPTER THREE: DATA AND METHODS OVERVIEW

This dissertation is an inductive, qualitative and longitudinal single case study (Eisenhardt, 1989; Yin, 2009) designed to reveal how post-merger integration performance shifts over time. Since my aim is to elaborate theory, I employ a grounded theory approach (Corbin & Strauss, 2008; Miles & Huberman, 1994; Strauss & Corbin, 1998) to better understand these unexplored dynamics. Inductive, qualitative methods are appropriate for at least two reasons. First, my research question focuses on a process or *how* something occurs, and qualitative research is appropriate to address questions about process (Creswell, 1998). Second, an inductive approach is appropriate since my aim is not to test theory or predict causal relationships, but to build and elaborate theory (Strauss & Corbin, 1990). In theory building and theory elaboration, extant theory influences the initial research design (Lee, Mitchell, & Sablinski, 1999), but the purpose is to “fill in” unknown relationships and processes that may connect existing concepts. Yet for both theory building and elaboration, data collection, analysis, and theoretical development occur iteratively throughout the research process, contributing to the development of a “grounded theory” (Locke, 2001; Miles & Huberman, 1984; Strauss & Corbin, 1990).

This dissertation includes two inductive, qualitative empirical studies. In Chapters Four and Five, I reveal the methods that I used for each empirical study specifically, but here I provide an overall justification of the research context, description of the research setting, and a general overview of the data sources and analyses I used for both studies. The data sources for each study are described in Table 3.1, which also describes the data and quantity and provides a notation of the empirical chapter where it is used.

Justification of the Research Context

When determining a context in which to perform inductive, qualitative research, there must be congruence between the research question and the research context such that the context provides the researcher with a good opportunity to answer the research question at hand (Creswell, 1998; Marshall & Rossman, 2010; Maxwell, 1998). As such, there are several theoretical and practical considerations for ascertaining whether such an opportunity exists. First, it is important to find a research context where the phenomenon of interest would be clearly visible (Eisenhardt, 1989; Pettigrew, 1990; Yin, 2003). Second, from a practical perspective, it is important to find a research context where entry is possible and where participants would be willing and able to participate in the study (Feldman, Bell, & Berger, 2003). Finally, it is important to find a research context where the researcher can maintain a continuity of presence for as long as necessary to address his or her research questions (Feldman et al., 2003).

I initially sought a context where identity dynamics would be heightened in the context of post-merger integration. After considering a number of context possibilities, I decided that understanding identity dynamics among teaching hospitals in the US that have merged was well-suited to addressing my original research question about how multiple identities are used to create value in organizations during post-merger integration. As I became immersed in the context, it became clear that this context was well suited to addressing a refined research question about how organizations rebound from failure during post-merger integration.

Teaching hospitals in the United States. In the United States, teaching hospitals account for more than \$587 billion of the nation's revenue and nearly 3.5 million full-time jobs (Umbach, 2012). Hence, they have substantial economic and social impacts on the regions, counties, and cities in which they operate and all regions of the country rely on them for job creation, medical care, advanced research, new business development, and education of health

care professionals (Umbach, 2012). Yet, managing their multiple identities has been a longstanding tension for teaching hospitals who are challenged to provide high-quality training and patient care while conducting innovative research, simultaneously, in cost-effective ways (Bunton & Henderson, 2013). Hence, individuals who can enact their multiple identities as clinicians, researchers, teachers, and managers to manage these competing responsibilities are in high demand (Ackerly et al., 2011; Dister, 2006; Radecki, 1986; Schwartz & Pogge, 2000).

Teaching hospitals in the United States in general provide a good organizational context for understanding both identity and M&A dynamics for several reasons. First, teaching hospitals are situated in a rather turbulent environment. Specifically, the health care industry in the US as a whole is experiencing financial constraints due to market forces and changes in reimbursement including a substantial increase in the number and cost of chronic diseases, diminishing financial resources with respect to the following: cuts in governmental support, state appropriations, Medicaid and Medicare payments, and funding for NIH research (Bunton & Henderson, 2013). In the past, teaching hospitals have responded to such environmental pressures by developing integrated clinical delivery systems, merging their operations with other teaching hospitals to form larger patient care service networks and contracting with large-scale purchasers of care, like business and corporations, to control costs and preserve their patient base (Aiken, Clarke, & Sloane, 2000; Bunton & Henderson, 2013; Schwartz & Pogge, 2000; Sochalski, Aiken, & Fagin, 1997). The passage of the Patient Protection and Affordable Care Act in 2010 has motivated teaching hospitals to continue to develop new delivery and patient care models (i.e., new resources) that would enable them to provide more cost-effective and high-quality care (Bunton & Henderson, 2013). Changes such as these can not only impact the work that one does, but can

also impact individuals' self-definitions (Pratt & Ashforth, 2003). Notably, scholars propose that changes in work can lead to changes in identity (Pratt & Ashforth, 2003; Pratt et al., 2006).

Second, teaching hospitals have multiple organizational identities which can also have implications for self-definition at the individual level (Pratt & Foreman, 2000); teaching hospitals are simultaneously educational institutions, research institutions, and health care delivery centers (AAMC, 2013). As educational institutions, teaching hospitals provide clinical settings for the education and training of medical students, medical residents, nurses, and other health professionals. As research institutions, teaching hospitals also engage in clinical research, including the testing and development of drugs, medical devices, and treatment methods. Finally, as health care delivery centers, teaching hospitals provide a variety of health care services to individuals living in and around the communities in which they are situated. Hence, anyone working in teaching hospitals can have multiple individual-level identities as well.

Based on these factors, I decided that a teaching hospital would be a good organizational context for answering my original research question related to multiple identity dynamics during post-merger integration as well as my refined research question related to how organizations rebound from failure during post-merger integration.

Research Setting³

This dissertation study spans the years 1998 to 2014. Chapter 4 includes data from 1998 to 2013 and Chapter 5 includes data from 2012 to 2014. I gained access to Community Hospital [hereafter, "Community"] and AMC Hospital [hereafter, "AMC"], two hospitals in the Northeastern United States located approximately three miles away from one another. Community is a 150- bed non-profit community teaching hospital with approximately 1,500

³ All names of organizations and their members are pseudonyms.

employees and AMC is a nearly 800-bed non-profit academic medical center with more than 10,000 employees. Since they first merged in 1998, Community and AMC had been trying to form a new and innovative integrated health care delivery system in order to enhance the utilization of patient care facilities at both hospitals (i.e., patient room occupancy, use of operating rooms) with limited success. To illustrate, since the time preceding the merger, Community had an excess of empty patient beds and unused operating room space. At the same time, AMC was overutilized and did not have sufficient physical capacity to treat the complex medical cases that were more aligned with its goals. Thus, one of the goals in forming an integrated health care delivery system was to share resources (i.e., patients and space) and improve the effectiveness of care at both hospitals. Yet, by 2010, it was clear that post-merger integration efforts were failing since resource sharing had not improved substantially over the years. As a result, both hospitals were experiencing revenue and patient care issues.

Overview of Data Sources and Analyses

I used the same basic analysis strategies in both studies. I initially used stratified purposeful sampling (i.e., theoretically driven sampling that begins to elucidate the key phenomenon of interest; Miles & Huberman, 1994) based on formal leadership position and organizational membership that would enable me to create contrasts and facilitate comparisons within the data to allow for a deeper understanding of the phenomenon of interest. As my data collection and analysis progressed and themes began to emerge, I shifted to theoretical sampling based on the desire to collect data that elaborated and refined emerging categories and themes (Charmaz, 2006; Corbin & Strauss, 2008).

I used multiple sources of evidence to understand identity dynamics in the post-merger integration context (Yin, 2009). Using multiple data collection techniques allowed triangulation

(i.e., cross-checking data for regularities across sources; Denzin, 2009) and bolstered the trustworthiness of the findings (Lincoln & Guba, 1985). Specifically, I conducted semi-structured interviews and collected archival materials as primary data sources and conducted overt, non-obtrusive observations as a secondary data source to corroborate interview and archival data.

Similar to Pratt (2000a: 460), I used “within method” techniques (i.e., compared qualitative data across data sources; Denzin, 2009) to triangulate findings from different sources to build stronger assertions about my judgments and interpretations. However, common to inductive, qualitative research, I became attuned to other dynamics upon entering the context, namely, a tension between unity and distinctiveness that seemed to be influencing identity dynamics (Chapter 4). Therefore, following Spradley (1980), I revised my focus to be more consistent with the dynamics I was witnessing in the context, namely, how the tension between unity and distinctiveness was managed over time and how managing the tension affected post-merger integration performance over time (Chapter 4). This revision motivated me to collect more archival data and to speak with lower-level managers.

In an iterative fashion, I employed a theory-building approach and analyzed the data from all three sources by traveling back and forth between the data and an emerging data structure of theoretical arguments (Corbin & Strauss, 2008; Locke, 2001; Miles & Huberman, 1994; Pratt et al., 2006). The analyses for Chapters Four and Five both utilized four major steps (adapted from Pratt et al., 2006):

Step 1: Data condensing. As I collected data, I used several tools including contact summary forms and a field journal to help me capture, make sense of, and condense the data in preparation

for more specific data analysis and theory development. This step also enabled me to begin theorizing. The following were some of the data condensing techniques I used.

Contact summary forms. I completed contact summary forms for each observation, interview, and archival document to document the provisional categories and reoccurring topics related to the name change (Miles & Huberman, 1994). Contact summary forms allowed me to consider the main concepts, themes, issues, and questions that were observed during the contact. As such, it was an efficient way to reduce data without losing important details.

Field journal. During all observations and interviews, I wrote notes in a field journal when it was feasible to do so. Real-time journaling allowed me to record my thoughts, reflections, reactions as I was experiencing them (Eisenhardt, 1989). When it was less feasible to write notes in real-time (e.g. it would disrupt the interactions in the context), I wrote or audio-recorded notes using a handheld recording device within 24 hours of the contact. The field journal contained reflective remarks on ideas that were sparked by observations, interviews, and archival records about data analysis and proposed codes without actually coding the data (Miles & Huberman, 1994). It was important because it helped me to establish some of the most salient dynamics in the context including the tension between unity and distinctiveness (Chapter 4).

Step 2: Open coding. In the second stage of data analysis, I coded the “raw” data in the interview transcripts. I then identified statements informants made regarding their views of the world to form open codes (Locke, 2001). Next, I reviewed all of the interview data again to see which, if any, fit each category. Finally, I compared across data sources to determine which codes were most relevant. For example, several early data fragments in the interviews suggested that some managers’ were interpreting the power dynamics in the merger relationship in positive ways while others were interpreting them in negative ways or in ways that suggested that they

were ambivalent about those dynamics (Chapter 5). As I compared these data fragments to others in my memos about “equality/inequality” and “valuing/devaluing”, I was able to develop open codes about “statements about perceiving equality/inequality in the relationship” and “statements about being valued/devalued” (Chapter 5).

Step 3: Creation of axial codes. In the third stage of analysis, I integrated open codes to create broader and more abstract axial codes (Corbin & Strauss, 2008; Locke, 2001). Axial codes were compared for similarities and differences in order to clarify relationships that exist between codes (Locke, 2001). Also, at this stage, codes were compared to broader conceptual categories. For example, I compared codes about “statements about perceiving equality/inequality in the relationship” and “statements about being valued/devalued” to create the axial code, “power schema” (Chapter 5).

Step 4: Delimiting theory by aggregating theoretical dimensions. At this final stage of analysis, axial codes were considered together in order to understand how the concepts related to one another, so that underling theoretical dimensions could be determined. These theoretical dimensions were then used to form a broad theoretical picture of the data. Lastly, I conducted “member checks” with 13 of my informants to verify that the emergent theoretical framework best explained the dynamics in the research context without doing “undue violence” to the experience of the participants in the context (Pratt, 2000).

CHAPTER FOUR: MULTIPLE IDENTITY RESOURCING AT THE ORGANIZATIONAL LEVEL DURING POST-MERGER INTEGRATION

ABSTRACT

In the context of mergers and acquisitions (M&As), there are pressures for the organizations involved to be both “similar” and “different.” Extant research recognizes this tension, but lends little insight into how it is managed at the organizational-level or the implications of doing so for post-merger integration performance. Based on an inductive, qualitative and longitudinal field study of two hospitals, “AMC” and “Community” (pseudonyms) using 69 interviews and 16 years of archival records as primary data sources, and 450 hours of observations as a secondary data source, I find that managing multiple organizational identity dynamics (i.e., an unmanaged tension between organizational identity-based unity and distinctiveness) was critical to greater synergy realization (i.e., enhanced resource sharing and resource generation). I reveal how through a process I call “multiple identity resourcing,” managers engaged in *emergent and deliberate* activities to manage organizational identity dynamics and to create greater synergy. I conclude by offering implications for theory and future research.

Mergers and acquisitions (M&As) are a global phenomenon and a strategy that is used to foster innovation and growth (e.g., Ahuja & Katila, 2001; Cloudt, Hagedoorn, & Van Kranenburg, 2006). Recently, investment experts have reported that M&A activity has returned to a level seen just before the 2008 financial crisis (Koons, 2014; Reklaitis, 2014; Solomon, 2014). While some would view the resurgence in M&A activity as “encouraging” (e.g., Hammond, 2014), others might see this phenomenon as potentially problematic.

It has long been noted that the failure rate of M&As is consistently high—estimates range from at least 50 percent and sometimes as high as 83 percent (e.g., Cartwright & Schoenberg, 2006; Weber, Oberg, & Tarba, 2013). The management literature (i.e., strategy, organizational theory, and organizational behavior) has provided several explanations for poor M&A performance as well as solutions for mitigating the challenges. Some research suggests that many M&As fail because of strategic and process factors such as failure to achieve “strategic fit,” poor integration strategies, and poor decision-making and negotiation processes (e.g., Cartwright & Schoenberg, 2006). In light of these strategic and process issues, scholars propose that firms should only merge with or acquire “related” firms (i.e., those with similar resources, target markets, market positioning) which can make the integration process easier (e.g., Homburg & Bucerius, 2006).

In a similar vein, other research focuses on the cultural and identity dynamics at play (e.g., Cartwright & Cooper, 1993; Clark et al., 2010; Kavanagh & Ashkanasy, 2006). Much of this research suggests that “cultural differences” in the way or type of work done -- including differences in deeply held beliefs, values, and assumptions about work, organizational structures, systems, and formal processes -- can interfere with the union of two organizations (e.g., Cartwright & Cooper, 1993). As such, research proposes “cultural integration” or achieving

“cultural fit” can be critical during post-merger integration (Cartwright & Cooper, 1993; Chatterjee et al., 1992; Larsson & Finkelstein, 1999).

Research has also suggested that identity issues can impede M&A performance. Taking a social identity theory approach (Tajfel & Turner, 1979; Tajfel, 1978; Turner, 1982), scholars have revealed how mergers promote “us vs. them” dynamics that contribute to intergroup bias and conflict (Gaertner & Dovidio, 2000; Gaertner et al., 1993). As a result, developing a “common ingroup identity” or recategorizing organizational identity from two organizations to a new post-merger organization can be important to merger success (e.g., Clark et al., 2010; Gaertner & Dovidio, 2000). Taken together, research on strategic management, organizational culture, and organizational identity each point to the importance of unity via similarity: either merging with a similar organization, or engaging in attempts to make two merged organizations more similar.

Yet, there are also several reasons why maintaining distinctiveness, in addition to unity, may be advantageous to merger success. From a strategic management perspective, as firms merge with or acquire other firms that are different in some way, they can acquire new resources including knowledge and financial capital (Hitt, Hoskisson, Johnson, & Moesel, 1996). Thus, it may be critical for two firms that are merging to be different. Further, maintaining distinctiveness in M&As may enable new information to be used to solve problems particularly when the new knowledge is gained through the merger (i.e., externally; Cohen & Levinthal, 1990). Additionally, from a cultural perspective, differences in organizational culture may also provide potential for value creation (Teerikangas & Very, 2006). For example, research on top management team (TMT) compatibility reveals how differences in TMT members’ functional backgrounds (i.e., TMT complementarity) – which they argue are linked to cultural beliefs,

assumptions, and values (Teerikangas & Very, 2006)—can have a positive impact on M&A performance (Krishnan, Miller, & Judge, 1997; Larsson & Finkelstein, 1999). Notably, expanding the skill set of TMTs by integrating TMT members' different functional/cultural experiences may promote organizational learning (Krishnan et al., 1997). Finally, from an identity perspective, recategorizing organizational identity from two groups to one may promote identity threat and resistance (Crisp et al., 2006). Therefore, preserving the distinctiveness of two firms can reduce threat and resistance (cf., Crisp et al., 2006; Hogg & Terry, 2000). Thus, from the above discussion, we learn that maintaining distinctiveness to some extent may be fruitful for M&A success.

Juxtaposing needs for being similar and being different suggests that there is a tension between unity and distinctiveness in the context of M&As. Some have suggested that creating identity-based unity while maintaining identity-based distinctiveness in the context of M&As is fruitful. Notably, Langley and colleagues (2012) identified such a tension in their paper which investigates “group identity work” in the early stages of two different mergers and the implications of a merger for different groups' and individuals' self-understandings. They found that employees in merged organizations managed pressures to become more similar while trying to maintain their distinctiveness by reconstituting their group identities for themselves and others. Yet, the authors did not investigate how this tension is managed at the *organizational*-level or its impact on post-merger integration performance-related outcomes. As such, we lack insight into cross-level dynamics at play in the process of managing identity-based tensions between unity and distinctiveness, namely, understanding of how managers manage *organizational* “identity struggles” (Langley et al., 2012) and shape multiple organizational identities and broader performance outcomes during post-merger integration. The lack of research aligned with these

issues led me to ask: *“How do managers in two organizations that have struggled to integrate manage the tension between identity-based ‘unity’ and ‘distinctiveness’? How does managing this tension affect post-merger integration performance?”*

I examined this research question through an inductive, qualitative and longitudinal study of two hospitals, “Community” and “AMC” (both pseudonyms) during a particularly protracted post-merger integration (between 1998 and 2013) that was intended to form a new, innovative and integrated health care delivery system. I began my field work in 2013 shortly after Community’s name had been changed to “AMC’s Community Hospital” and AMC and Community’s parent company had been renamed, “AMC Healthcare.” I soon learned that “the name change” (as leaders referred to these events) was pivotal in the context and was perceived to be critical to merger success. With this in mind, I decided to examine the events leading up to and immediately following this critical event, concentrating on the period between 2010 and 2013. During data collection, I was immediately struck by the long-standing and deeply embedded tension between creating unified structures and processes and continuing to maintain distinct operations post-merger agreement in spite of an initial sense across both organizations that the merger relationship was intended to be mutually beneficial with respect to sharing resources (i.e., transferring patients awaiting a room to a hospital with underutilized bed space). Further, I was surprised by the length of time that it was taking to integrate the two organizations given the general consensus that the terms of the merger and events surrounding the decision to merge in 1998 were “friendly.” In addition, I was also intrigued by the sheer amount of “identity work” that managers across the two organizations engaged in to realize greater synergy from their relationship. What emerged from my data was evidence that even though the merger was framed as a resource issue (i.e., utilization of patient beds, need for space), an emergent and

identity-based strategic change process I call “multiple identity resourcing” was critical for gaining traction on resolving the resource issue.

The emergent theory of *multiple identity resourcing* elaborates theory on multiple organizational identity management (Pratt & Foreman, 2000) and M&A performance (Ahuja & Katila, 2001; Capron & Pistre, 2002; Teerikangas & Very, 2006). Specifically, this study contributes to research on multiple organizational identities by revealing heretofore unrevealed dynamics about how managers manage the tension between organizational unity and distinctiveness, complementing and extending work that has examined how individuals manage this tension at the individual level (Brewer, 1991) and the group-level (Langley et al., 2012). In addition, this study contributes to research on multiple organizational identities by incorporating a resource based perspective on identity, complementing and extending work that has examined multiple identities as resources at the individual level in organizations (Caza & Wilson, 2009; Creary, 2015; Creary et al., 2015; Dutton et al., 2010; Ely & Thomas, 2001). Further, this study contributes to research on M&A performance by incorporating insights from strategy-as-practice research to examine specific activities that managers engage in to solve post-merger integration problems and to account for more proximal performance-based outcomes at lower levels of analysis (Jarzabkowski et al., 2007; Jarzabkowski & Kaplan, 2015; Vaara & Whittington, 2012). Ultimately, this study reveals that what organizations will be and how they will perform post-M&A must be instantiated in the actual practices of its actors.

RELATING THE TENSION BETWEEN UNITY AND DISTINCTIVENESS TO M&A PERFORMANCE

Since this is an inductive, theory-building study, much of the literature I review in the section that follows became useful and apparent to me as I iterated between data and theory

during data collection and data analysis. Therefore, the literature review that follows is an overview of the theories that ultimately framed my research findings (Pratt et al., 2006).

The conceptual foundation for understanding the tension between unity and distinctiveness in the context of post-merger integration and how it affects post-merger performance originates from micro-level research on social identity theory where this tension is central (i.e., Brewer, 1991; Tajfel & Turner, 1979; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). According to social identity theory, individuals need to feel both similar to and different from others (Brewer, 1991). Notably, individuals seek to affiliate and belong to a social group while also maintaining clear boundaries from others in the group and from other social groups. “Optimal distinctiveness” is achieved when individuals achieve a balance between differentiation of the self from others in a social group and inclusion in a larger collective (Brewer, 1991).

While not focused on M&As specifically, research on organizational identity is more explicit about the tension between unity and distinctiveness at the organizational-level of analysis and its affect on performance. Drawing on Brewer’s (1991) notion of “optimal distinctiveness” and focusing on the tension between unity and distinctiveness within a *single* organization, Gioia and colleagues (2010) found that a new college needed to become similar enough to competitors while remaining different enough from them in order to gain legitimacy while amassing a competitive advantage. Likewise, Kreiner and colleagues (2014) revealed that understanding how an organization is different from yet similar to others is important to constructing organizational identity. In this paper, I also draw on optimal distinctiveness to propose how two organizations manage the tension between unity and distinctiveness post-merger.

The notion that there is a tension between unity and distinctiveness in the M&A context and that it has an impact on M&A performance has been implied in the broader M&A literature (Langley et al., 2012). Following Clark and colleagues (2010), I divide the M&A literature into two perspectives in order to reveal how this tension is manifested and what has been said about how it relates to M&A performance: strategy and culture in M&As; and organizational identity in M&As. I review both of these perspectives in more detail below.

The Role of Strategy and Culture in M&A Performance

The goal of M&A activity from a strategic management perspective is to create synergy, where synergy refers to an “increase in the merging firms’ competitive strengths and resulting cash flows beyond what the two companies are expected to accomplish independently” (Capron & Pistre, 2002: 782). Notably, synergy is gained from knowledge sharing (Ahuja & Katila, 2001; Capron & Pistre, 2002; Cohen & Levinthal, 1990). Frequently, top management team (TMT) culture or “the shared beliefs and assumptions held by a firm’s top management team” (Lubatkin, Schweiger, & Weber, 1999: 57) (Lubatkin et al., 1999: 57) is viewed as a proxy for larger organizational cultural dynamics including knowledge sharing (Chatterjee et al., 1992). Namely, Weber (1996: 1184) proposed that TMT’s beliefs and values “are expected to permeate and influence other levels of an organization. As such, the top management culture may be a reasonable manifestation of the organization’s overall culture.” Thus, when cultural differences between top management teams exist in M&As, cultural clashes will persist between the two combining organizations (Kavanagh & Ashkanasy, 2006)

Germane to the literature on strategy and culture in M&As is a debate over whether differences in organizational culture (e.g., Ravasi & Schultz, 2006; Schein, 1985) can help or hinder knowledge sharing and M&A success (Teerikangas & Very, 2006). Much of this body of

work asserts that differences in organizational culture are problematic for merger performance and, therefore, must be eliminated (e.g., Cartwright & Cooper, 1993; Chatterjee et al., 1992; Schweiger & Very, 2003). In particular, Cartwright and Cooper (1993) proposed that “cultural incompatibility” is a cause for poor M&A performance and occurs when differences in core values, beliefs, attitudes, and managerial style between two merged organizations clash. To remedy these issues, scholars contend that leaders should improve the degree of “cultural fit” between the organizations by integrating the cultures so that the result is one, unified culture. For example, Stahl and Voigt (2008) proposed that sociocultural integration, namely, the creation of positive attitudes toward a new merged organization and trust among organizational members can be used to facilitate greater synergy between two organizations with different cultures. As such, “relatedness” can be important (Hitt et al., 1996; King et al., 2004; Seth, 1990). Notably, merging firms are considered related “when a common skill, resource, market or purpose applies to each” (Rumelt, 1974: 29).

Other research takes an alternative perspective and proposes that differences in organizational culture can be good for merger performance. Drawing on the resource-based view of the firm (Barney, 1991), some scholars suggest that M&As can give organizations access to unique and valuable capabilities (e.g., Larsson & Finkelstein, 1999). Similarly, scholars have also suggested that cultural differences can help to develop richer knowledge structures which foster innovation and learning (Vermeulen & Barkema, 2001). For example, Krishnan and colleagues (1997) found that differences in functional backgrounds, or “complementary” backgrounds, among TMTs can enhance organizational learning. Specifically, differences in functional backgrounds can be used to help to offset weaknesses in both organizations to create or maintain competitive advantage. Notably, when functional backgrounds (and knowledge

bases by proxy) between TMTs are too similar, M&A activity may contribute little to M&A performance (Seth, 1990). As such, maintaining a diversity of knowledge, ideas, processes, etc. between TMTs and two merged organizations can be important to merger success.

Drawing on the above review, we can surmise that capitalizing on what makes two merged firms unique or different from one another from a strategy and cultural perspective is desirable for merger success, but can be difficult given pressures also to unify or consolidate. Yet, research on the larger M&A context does not reveal the specific practices in the post-merger integration context that are used to manage this tension or how different practices produce different outcomes. Instead, existing research on strategy and culture in M&A performance gives reasons to support why unity *or* distinctiveness may be “better”: therefore, positively affecting organizational performance.

Managing Organizational Identity in M&As⁴

Research on managing organizational identity in the M&A context says little about performance outcomes but does help us to understand managerial practices that may affect M&A performance. Organizational identity refers to conceptualizations about “who we are” as an organization (Corley et al., 2006; Fiol, 1991; Hatch & Schultz, 2002; Ravasi & Schultz, 2006). There are two perspectives on the role of identity dynamics in M&As: a social psychological perspective and an organizational identity perspective.⁵ The social psychological perspective

⁴ Organizational culture and organizational identity are interrelated, yet, distinct concepts. In their interpretation of Fiol (1991), Ravasi and Schultz (2006: 437) state, “organizational identities help members make sense of what they do—as defined by tacit cultural norms and manifested in visible and tangible artifacts—in relation to their understanding of what the organization is.” Therefore, organizations draw upon culture for sensemaking. I relate organizational identity and organizational culture in the same way in this paper.

⁵ In reviewing the M&A literature, I also considered research looking at the psychological impact of M&As, particularly on pre- and post-merger identification (e.g., Terry, 2001; Van

draws on social psychological theories of intergroup behavior (i.e., Sherif & Sherif, 1969; Tajfel & Turner, 1979). In so doing, scholars reveal how mergers often promote “us vs. them” dynamics that contribute to intergroup bias and conflict (Gaertner & Dovidio, 2000; Gaertner et al., 1993). Gaertner and colleagues (1993) proposed the “common ingroup identity model” as way of reducing intergroup bias and conflict. Specifically, the authors argue that inducing two, distinct groups to view themselves as a single, cohesive group through “recategorization” can foster more positive employee attitudes post-merger. In this respect, the authors propose that the creation of a common “superordinate group” that is inclusive of members of both groups is critical to merger performance.

A smaller group of scholars do not draw on the common identity model but have attempted to look at organizational identity dynamics in an M&A context (i.e., Clark et al., 2010; Vaara & Tienari, 2011). Specifically, Clark and colleagues (2010) found that the creation of a “transitional identity” was important for moving a change process forward and legitimating a merger. Specifically, in an early phase of a merger, executives from two management teams created a temporary name for the future merged organization in order to develop a common understanding of “who we will be.” This transitional identity enabled leaders from both teams to remain positively engaged in merger activities. Similarly, Vaara and Tienari (2011: 380) revealed how top management used narratives to construct a joint “Nordic” identity in order to legitimate a merger between Swedish, Finnish, Danish, and Norwegian corporations and form “a proper MNC organization.”

Dick, Wagner, & Lemmer, 2004; Van Knippenberg & Van Leeuwen, 2001). While this research is important for understanding micro-level issues in the M&A context, it does not specifically address identity-related processes and dynamics at the organizational-level.

Research focused on the “identity struggles” of groups of employees in a merger context also reveals a tension between unity and distinctiveness at the *group*-level in a merger context (Langley et al., 2012). Namely, Langley and colleagues (2012) revealed how different groups of employees engaged in four different patterns of identity work in language, practices, and space to manage tensions they were experiencing between sameness and distinctiveness. For instance, the “maverick” pattern entailed using identity talk to resist pressures for sameness while promoting their own distinctiveness and pushing others to join them. The “fighter” pattern also involved resisting sameness while promoting distinctiveness, but focused on using old labels to reference their distinctiveness in a variety of situations. The “adapter” pattern involved adapting new managerial language to express their identities effectively accommodating pressures for sameness without trying to maintain distinctiveness. Finally, the “victim” pattern involved narrating an expected future that was worse than the past. Those using the victim pattern reinforced how pressures for sameness suppressed their ability to sustain their sense of distinctiveness.

Similarly, other research not focused on M&As specifically has suggested that in spite of pressures toward sameness, pressures toward distinctiveness continue to be strong in the context of organizational identity (Gioia et al., 2010; Kreiner et al., 2014; Pratt & Foreman, 2000). For instance, in a paper about multiple organizational identities, Pratt and Foreman (2000) proposed that organizations can manage organizational identity dynamics in ways to realize their benefits while minimizing their costs. For instance, having multiple organizational identities can negatively impact strategic decision making because of competing “mental maps” of “who we are” (e.g., Fiol & Huff, 1992). Thus, emphasizing “sameness” by creating one unifying identity may be a good strategy when plurality is problematic for organizations. Yet, maximizing

identity differences can be more optimal when it enables an organization to respond better to a complex organizational environment (e.g., Albert & Whetten, 1985). Bearing these potential outcomes in mind, the authors organized a conceptual framework of four managerial responses to managing multiple organizational identities based on the desired level of plurality (maintaining vs. reducing multiplicity) and synergy (creating overlap or separation): compartmentalization, deletion, integration, and aggregation. Compartmentalization responses emphasize distinctiveness by preserving all identities in question without seeking to attain any synergy among them. Deletion responses expunge one or more organizational identities when identities are not synergistic such as when organizations cannot afford to maintain multiple identities. Integration responses emphasize sameness by combining all identities into a distinct new whole aiming to reduce plurality while building on synergy. Finally, aggregation responses emphasize both sameness and distinctiveness by retaining all organizational identities and create links among them, aiming to create high synergy while maintaining high plurality. This paper, however, does not delve deeply into how these strategies are achieved.

In summary, my review of the literature on M&As suggests that a tension between unity and distinctiveness can be pervasive during post-merger integration, yet we do not yet understand the activities that are involved in managing this tension particularly at the organizational-level, or how managing this tension affects post-merger integration performance. Hence, in this paper, I pose the following research question: “How do managers in two organizations that have struggled to integrate manage the tension between identity-based ‘unity’ and ‘distinctiveness’? How does managing this tension affect post-merger integration performance?” I focus on the organizational identity dynamics and not the organizational culture

dynamics in this paper given that my data suggest that issues of “who we are” and are not were figural in the context.⁶

METHODOLOGY

This paper is an inductive, qualitative and longitudinal single case study (Eisenhardt, 1989; Yin, 2009) designed to understand how management teams from two organizations that have merged manage the tension between creating unity and maintaining distinctiveness and how such management affects their post-merger performance. Data span the years 1998 to 2013. Inductive, qualitative methods are appropriate for at least two reasons. First, my research question focuses on a process or *how* something occurs. Notably, process theories explain the sequences of events, activities, and choices that lead to an outcome (Langley, 1999; Langley & Tsoukas, 2010; Mohr, 1982; Pratt, 2012). Process theories are also concerned with how phenomena unfold over time and why they evolve in that way. Hence, qualitative research is appropriate since my research question focuses on *how* something occurs and why it evolves in that way (Creswell, 1998). Second, an inductive approach is appropriate since my aim is not to test theory or predict causal relationships, but to build and elaborate theory (Strauss & Corbin, 1990). In theory elaboration, extant theory influences the initial research design (Lee et al., 1999), but the purpose is to “fill in” unknown relationships and processes that may connect existing concepts. Yet for both theory building and elaboration, literature review, data collection, analysis, and theoretical development occur iteratively throughout the research process, contributing to the development of a “grounded theory” (Locke, 2001; Strauss & Corbin, 1990). Table 4.1 includes a timeline of of literature review, data collection, and data analysis.

⁶ Even though informants used both “culture” and “identity” as language to describe the dynamics in this context, ultimately, they were talking about “who we are.”

Insert Table 4.1 About Here

Research Setting and Sample

I initially sought a context where identity dynamics would be heightened in the context of post-merger integration. After considering a number of context possibilities, I decided that understanding identity dynamics among teaching hospitals in the US that have merged was well-suited to addressing my original research question about how multiple identities are used to create value in organizations during post-merger integration. Specifically, the health care industry in the US as a whole is experiencing financial constraints due to market forces and changes in reimbursement (Bunton & Henderson, 2013). In the past, teaching hospitals have responded to such economic pressures by developing integrated clinical delivery systems, joining their operations with other teaching hospitals to form larger patient care service networks (Aiken et al., 2000; Bunton & Henderson, 2013; Schwartz & Pogge, 2000; Sochalski et al., 1997). Therefore, managing identity dynamics is critical for a hospital's success. However, common to inductive, qualitative research, I became attuned to other dynamics upon entering the context, namely, a tension between unity and distinctiveness that seemed to be influencing identity dynamics and creating performance issues (i.e., resource sharing challenges). Therefore, following Spradley (1980), I revised my focus and research question to be more consistent with the dynamics I was witnessing in the context.

I gained access to Community Hospital [a pseudonym and hereafter, "Community"] and AMC Hospital [a pseudonym and hereafter, "AMC"], two hospitals in the Northeastern United States located approximately three miles away from one another. Community is a 150- bed non-

profit community teaching hospital with approximately 1,500 employees and AMC is 793-bed non-profit academic medical center with more than 10,000 employees. Since they first merged in 1998, Community and AMC had been trying to enhance the utilization of patient care facilities at both hospitals (i.e., patient room occupancy, use of operating rooms) with limited success. Namely, AMC needed more space to treat its patients and Community needed more patients to occupy its space. Yet, by 2010, it was clear that post-merger integration efforts were failing since utilization had not improved substantially over the years. Hence, the hospitals were failing to actively improve resource sharing which was a central strategic goal.

I initially used stratified purposeful sampling (i.e., theoretically driven sampling that begins to elucidate the key phenomenon of interest; Miles & Huberman, 1994) based on formal leadership position and organizational membership, and focused specifically on managers who were involvement in the development of the new integration strategy. This sampling strategy enabled me to create contrasts and facilitate comparisons within the data to allow for a deeper understanding of the phenomenon of interest and was chosen in light of research suggesting that identity dynamics in the M&A context may differ by level in the hierarchy (Corley, 2004), organizational membership (van Knippenberg et al., 2002), and involvement in strategy development (Corley & Gioia, 2004). Specifically, I worked with a senior manager at Community to create a list of managers at both organizations who were “highly involved” in developing the integration strategy and could share insights on the merger relationship to date. As a result, I initially spoke with a select group of senior managers (i.e., administrative senior executives, chairs and chiefs of clinical/medical services) at Community and AMC.

As my data collection and analysis progressed and themes related to unity and distinctiveness began to emerge, I shifted to theoretical sampling in order to collect data that

elaborated and refined emerging categories and themes related to how the tension between unity and distinctiveness was managed through organizational identity change (Charmaz, 2006; Corbin & Strauss, 2008). Namely, I also began speaking with middle managers (i.e., and directors and executive directors of clinical and administrative departments) who I learned were also involved in several activities related to developing new organizational identities and I began collecting more archival data (e.g., strategy planning documents) to account for the factors influencing organizational identity change.

Data Collection

I used multiple sources of evidence to understand how managers from both organizations managed the tension between unity and distinctiveness between 2010 and 2013 (Yin, 2009). Using multiple data collection techniques allowed triangulation (i.e., cross-checking data for regularities across sources; Denzin, 2009) and bolstered the trustworthiness of the findings (Lincoln & Guba, 1985). Specifically, I conducted semi-structured interviews and collected archival materials as primary data sources and conducted overt, non-obtrusive observations as a secondary data source. Table 4.2 includes an overview of my data sources including a detailed breakdown of the type and quantity of data per data source.

Insert Table 4.2 About Here

I interviewed 55 managers (senior, middle, and former) and conducted 69 interviews. Fourteen of these interviews were follow-up interviews (i.e., “member checks”) with 13 senior managers to verify that the emergent theoretical framework best explained the dynamics in the research context without doing “undue violence” to the experience of the participants in the

context (Pratt, 2000). For each interview, I used a tailored semi-structured interview protocol (per informant type, e.g., physician-manager). The interview protocol for the initial and follow-up interviews included grand and mini-tour questions designed to help me understand the merger context including how each informant viewed it and viewed their role within it (cf., Spradley, 1979). Please refer to the Appendices for an example of the protocols.

In addition to interviewing, I obtained 16 years of archival data as a second primary data source to counterbalance the retrospective nature of the interviews in detailing the history behind the initial merger and the integration efforts. Archival data include quarterly and annual reports and presentations, newspaper and online reports, organization-wide memos and emails, details of specific projects, employee handbooks, policy manuals, mission statements, and books about the teaching hospitals (Yin, 2009). Senior and middle managers I interviewed gave me access to many of these documents.

Finally, I conducted 450 hours of observations as a supplementary way of understanding what was happening in the context as a consequence of both earlier and later integration efforts. Instead of engaging directly in the work, I took on the role of “observer-as-participant,” which means that I interacted somewhat with those I studied on-site, but the interactions were more casual and passive without interfering with the people or activities under observation (Angrosino & Perez, 2005; Pratt & Kim, 2012). Specifically, I observed strategic planning meetings, leadership meetings, departmental meetings, hospital-wide staff meetings, committee meetings, patient care areas, morning rounds, and general phenomena in public areas at each hospital. Observations were overt in nature, such that managers and others who interacted with them knew that they were being observed and of my role as a researcher (Whyte, 1984). Over time, observations became more structured as I proceeded with data collection from observing leaders

in an “open” manner to developing a more focused observation protocol. This approach allowed me to understand the merged organizations in a general sense and then, more specifically, how the tension between unity and distinctiveness had been managed in this context. For example, some of the observations allowed me to hone in on the use of the word “Family” in meetings and public spaces to clarify the relationship between Community and AMC. These observations turned my attention to investigating how the word “Family” was used between 2010 and 2013 specifically.

Data Analysis

Similar to Pratt (2000a: 460), I used “within method” techniques (i.e., compared qualitative data across data sources; Denzin, 2009) to triangulate findings from different sources to build stronger assertions about my judgments and interpretations on how the tension between unity and distinctiveness was managed over time. In an iterative fashion, I employed a theory-building approach and analyzed the data from all three sources by traveling back and forth between the data and an emerging data structure of theoretical arguments (Corbin & Strauss, 2008; Locke, 2001; Miles & Huberman, 1994; Pratt et al., 2006). This analysis utilized four major steps (adapted from Pratt et al., 2006):

Step 1: Data consolidation. As I collected data, I used several tools including contact summary forms, a field journal, and memos to help me capture, make sense of, and reduce the data in preparation for more specific data analysis and theory development. The following were some of the data consolidation techniques I used.

Contact summary forms. I completed contact summary forms for each interview, observation, and archival document to document the reoccurring topics related to meaning construction and relational dynamics (Miles & Huberman, 1994). Contact summary forms

allowed me to consider the main concepts, themes, issues, and questions that were observed during the contact. As such, it was an efficient way to reduce data without losing important details. For example, contact summary forms from June to November 2013 suggested that managers viewed “the name change” as a pivotal event in the context—one that was critical to integration “success.”

Field journal. During all observations and interviews, I wrote notes in a field journal when it was feasible to do so. Real-time journaling allowed me to record my thoughts, reflections, reactions as I was experiencing them (Eisenhardt, 1989). When it was less feasible to write notes in real-time (e.g. it would disrupt the interactions in the context), I wrote or audio-recorded notes using a handheld recording device within 24 hours of the contact. The field journal contained reflective remarks on ideas that were sparked by observations, interviews, and archival records about data analysis and proposed codes without actually coding the data (Miles & Huberman, 1994). It was important because it helped me to establish some of the most salient dynamics in the context, including how a broader organizational identity negotiation process (i.e., claiming, identity work, granting) was being used to increase integration.

Step 2: Open coding. In the second stage of data analysis, I coded the “raw” data in the interview transcripts. I then identified statements informants made regarding their views of the world to form open codes (Locke, 2001). Next, I reviewed all of the interview data again to see which, if any, fit each category. Finally, I compared across data sources to determine which codes were most relevant. For example, several early data fragments in the interviews suggested that “resources” were contested in the context. As I compared these data fragments to others in the archival records about “utilization” in both hospitals, I was able to develop open codes about

“wanting a mutually beneficial relationship” to manage utilization issues and “wanting to maximize Community’s resources.”

Step 3: Creation of axial codes. In the third stage of analysis, I integrated open codes to create broader and more abstract axial codes (Corbin & Strauss, 2008; Locke, 2001). Axial codes were compared for similarities and differences in order to clarify relationships that exist between codes (Locke, 2001). Also, at this stage, codes were compared to broader conceptual categories. For example, I compared codes about “wanting a mutually beneficial relationship” to manage utilization issues to codes about “wanting to maximize Community’s resources” to create the axial code, “pressures to unify.”

Step 4: Delimiting theory by aggregating theoretical dimensions. At this final stage of analysis, axial codes were considered together in order to understand how the concepts related to one another, so that underling theoretical dimensions could be determined. These theoretical dimensions were then used to form a broad theoretical picture of the data. Lastly, as noted, I conducted “member checks” with 13 of my informants to verify that the emergent theoretical framework best explained the dynamics in the research context without doing “undue violence” to the experience of the participants in the context (Pratt, 2000). From this analytical step, I established the “tension between unity and distinctiveness” in the context, “organizational identity negotiation” as a critical process, and “synergy realization” as a key outcome of this process.

FINDINGS

Figure 4.1 (adapted from Corley & Gioia, 2004) summarizes the coding process I followed and the findings, which shows three aggregate theoretical dimensions that emerged from my analysis (right side of the figure), as well as the axial codes (middle of the figure), and

open codes (left side of the figure). The three aggregate theoretical dimensions that emerged were a tension between unity and distinctiveness in the merger context; organizational identity negotiation; and synergy realization.

I begin with a descriptive account of how unity vs. distinctiveness was manifested over time. Then, I theorize how these dynamics emerged. In the first part of the descriptive account, I include raw data that were used to develop the open and axial codes. Following this, I move to a more abstract discussion of the findings and present a theoretical process model of “multiple identity resourcing.”

Insert Figure 4.1 about here

Phase I: Tension Between Unity and Distinctiveness Creates a Resource Sharing Issue (1998-2010)

Between 1998 and 2010, tension between unity and distinctiveness in the context of the merger between AMC and Community was manifested in two ways: wanting a relationship but also valuing autonomy and pressures to both integrate and separate programs and policies. At this time, this unmanaged tension was manifested in a resource sharing issue. Table 4.3 provides evidence of the tension between unity and distinctiveness.

Insert Table 4.3 about here

Wanting a relationship but also valuing autonomy. AMC and Community initially merged in 1998 because management teams thought that uniting the two hospitals would enable them to establish a mutually beneficial relationship. Notably, AMC had a surplus of patients and,

as a result, many patients were spending an extended length of time in the Emergency Department (ED) waiting for a room on a hospital floor. Although the costs of caring for patients with similar conditions were markedly lower at Community, Community was struggling to reach 50 percent capacity on hospital units. These challenges were creating patient care and financial concerns at both hospitals. Thus, leaders at Community and AMC agreed to merge and form a common parent entity/holding company, AMC/Community Hospital (AMC/C), which became a subsidiary of a larger network of hospitals of which AMC was already a member. It was also established that the president of AMC was to be appointed president of AMC/C. A senior leader at Community who had participated in negotiating the original agreement revealed:

The fundamental fact was [Community] had a bunch of empty beds and we needed to put people in them...AMC at the time was growing at an incredible rate, like 11 to 15 percent per year. Something crazy. Which was unsustainable. And there were a lot of patients over there taking up beds that didn't really need to be there. I'm not talking about some bone marrow transplant, coronary bypass patient. I'm talking about someone who needed a gallbladder operation or a hernia or a right colon resection. Stuff that we can do here perfectly well, in some respects much more efficiently and certainly much less expensively. [09S]

Similarly, a senior leader at AMC revealed:

...it was both in AMC's and Community's best interests to merge. Community was in dire straits. AMC wasn't really having difficult times then...reimbursement just wasn't good. But AMC...was pretty forward thinking in identifying that we would need to provide care at the right site of care for what the patient needed. And not every patient needed an academic medical center. [12S]

Despite seeing mutual benefits, each hospital decided it was in its best interests to retain its own board, administration, medical staff, and financial reporting system. At that time, a full-scale merger of assets and leadership was considered, but Community's patients and employees perceived a need to maintain the identity of Community as a distinct community hospital [archival documents]. These distinctions enabled both hospitals to maintain roughly equal power in the relationship initially although AMC was the larger and financially healthier organization.

By 2010, it was clear that Community's autonomy was problematic. Namely, the distinctions set forth in the original agreement enabled managers at Community to selectively accept input from managers at AMC even though they expected that AMC would provide Community with assistance, especially financial assistance whenever needed. Yet, managers at AMC were bothered by what they viewed as "a financial handout whenever times got tough" without sufficient input into Community's operations. At this time AMC managers were also speculating whether they actually "owned" Community. Senior managers at Community deferred to the original agreement, stating, "we agreed that Community would remain a freestanding teaching hospital" and "it was only supposed to be an affiliation" [various interviews].

Pressures to both integrate and separate. Initially, the tactics used to integrate the two hospitals post-merger centered on maximizing available resources. First, the medicine and surgery residency programs between the two hospitals were integrated, which enabled AMC's residents to be exposed to community hospital care. As physicians at both hospitals began to support this initiative, AMC and Community were able to work on other areas of integration, namely, moving patient volume from AMC to Community. Notably, select surgical cases and primary care practices were moved to Community and a few joint programs were established at Community as well. Yet, by 2010, actual efforts to integrate were minimal and there was some pressure to separate practices. In one respect, members of Community's senior management team felt that further integration of programs and processes might enable AMC to "take over" and "destroy the friendly culture" at Community that enabled it to provide the high-quality care to patients in the community that set it apart from its competitors. Therefore, members of the Community senior management team continued to keep members of the AMC management team

at “arm’s length.” In a different respect, AMC managers were finding it difficult to predict the patient volume at AMC given daily fluctuations in the census. This lessened AMC managers’ motivations to transfer patients from AMC’s Emergency Department to Community’s medical service. In addition, there were also issues with individual patients and physicians being unwilling to move care to Community because they did not perceive that the quality of care at Community was similar to that at AMC. Therefore, there was less commitment from AMC to participate in practices designed to increase the patient volume at Community. As a result, both hospitals were continuing to experience the same utilization issues they had been experiencing prior to the merger agreement.

While utilization issues had remained unresolved since 1998, changes in the national environment soon increased the experienced tension between unity and distinctiveness in these two hospitals. Specifically, by 2010 external pressures to improve the costs of health care were also contributing to the existing tension between integrating practices and keeping them separate. National and political discourse related to improving the affordability of health care in the US was pressuring hospitals and other health care institutions to engage in cost-saving measures. Further, by virtue of their membership in a larger network of hospitals in the area, AMC and Community became part of an initiative intended to lead to a designation as a Pioneer Accountable Care Organization (ACO) from the Centers for Medicare and Medicaid Services (CMS).⁷ If accepted as a Pioneer ACO, AMC and Community would need to work in coordination with CMS to reduce health care costs in order to receive other financial incentives. By all accounts, these external pressures placed greater attention on the need to unify existing processes and operations across the two organizations. Yet, these pressures also reminded

⁷ CMS is a federal agency with the US Department of Health and Human Services that administers federal programs related to health care.

managers of the need to maintain Community's low-cost structure, thus keeping the pressures toward distinctiveness strong as well. Although sharing administrative information easily was important, there was a sense that duplicating AMC's administrative control systems, including its electronic human resources would raise Community's operating costs. Therefore, there was considerable pressure to keep their operations separate.

Phase II: Resource Sharing Issue Leads to Organizational Identity Negotiation (2010 to 2012)

In the beginning of 2010, AMC hired a new president who was particularly interested in maximizing resource sharing between AMC and Community especially in light of health care reform measures. To add to this, a large medical group that had contracted with AMC to admit their patients to AMC and more of its community-hospital-level admissions to Community at lower rates, had just decided not to renew its contract with AMC. As a result, both hospitals were experiencing further resource utilization issues. In a magazine interview, AMC's president proposed that both hospitals would need to "explore our care delivery models and our cost structures...[in order to] redesign care" (archives). The new president's interest in the relationship grounded in pressures to control health care costs and the loss of the contract triggered an unplanned *negotiation* process, which culminated in a change in organizational naming practices (i.e., granting of organizational identity unity and distinctiveness). In this process, the negotiation of resources became embroiled in a contestation over identity that was enacted through practices that shaped identity dynamics. Table 4.4 provides additional evidence of organizational identity negotiation, including claiming a common identity, organizational identity work, and granting new organizational identities.

Insert Table 4.4 about here

Claiming a common identity. AMC’s new president initially tried to make sense of the relationship and the long-standing tension during individual meetings with managers at both AMC and Community. During these meetings, she learned of the “us” versus “them” dynamic in the relationship. Soon thereafter, AMC’s president began claiming at various leadership meetings that the two hospitals were “a Family” (c.f., “common ingroup identity,” Gaertner & Dovidio, 2000; Gaertner et al., 1993). In short, by claiming that both hospitals were a Family, the president shifted the dialogue about resources into a conversation about “who we are” as interdependent organizations.

There were negative reactions to this Family identity claim, including a perception at Community that the AMC president was over asserting herself in her role as president of the AMC/C holding company, something that the previous presidents at AMC had not done. One leader from Community said, “[The AMC President] said, ‘I’m now the President of both hospitals’ and that there was a new day; at least a new day for us. Let’s put it that way” [11S]. The Family identity claim triggered a series of activities at the top management team level designed to lend clarity on the relationship between the two hospitals. What emerged from this claim were activities (both emergent and deliberate) related to managing these organizational identity dynamics – i.e., “organizational identity work” (Kreiner et al., 2014). Specifically, managers began to engage in three types of organizational identity work activities: problematizing, sorting, and boundary work.

Organizational identity work: Problematizing activities (January 2010 – June 2011).

Broadly speaking, managers at both hospitals did not receive this common identity claim well.

Problematizing activities enabled them to understand why a common identity claim was troublesome.

Problematizing was revealed in how managers at AMC and Community openly questioned how and whether the Family identity claim was consistent with their own understandings of who they were. Notably, the Family identity claim was threatening for both organizations, but for different reasons. These reasons became clearer as each hospital began to articulate “who they were” especially in light of the other. To summarize, AMC claimed that it was an “international leader pioneering breakthroughs” while Community claimed that it was “a community leader...committed to quality and personal attention.” AMC claimed that it was committed to “excellence” in research and patient care while Community claimed that it was committed to “the community.” These distinctions made it difficult for managers from both hospitals to see themselves as “part of the same Family.”

These identity claims, known to both hospitals, were interwoven into their objections to the Family label. For example, managers at Community felt that considering Community as part of a larger “Family” would require that they relinquish the hospital’s autonomous identity and “become more like AMC.” They felt that these actions would inhibit their ability to provide the type of care that was part of Community’s identity and for which it was known. Community’s then President and CEO commented:

People go to AMC and they put up with all of the crap because the outcome is great, but they don’t go to Community unless they get treated well as people. When you move the mentality of AMC to Community with leaders like they have...[Community is] going to end up like a dangling participle of AMC that won’t be able to compete.

Another senior manager at Community proposed:

[We have] a responsibility to the community. It isn’t just to be [the] world-class research hospital that [AMC] is and advance human knowledge. It’s to take care of

patients....There are still a lot of very poor people who come to these hospitals and we can't and won't turn them away. We can't abandon that mission...[09S]

AMC managers were not happy either but their concerns were more about who Community was rather than who AMC was. Since the Family identity claim linked them more closely to Community, managers at AMC felt that the Family identity threatened AMC's identity, particularly, its claims related to "excellence" in research and patient care. One AMC manager commented on the challenge in believing that the quality of care at Community was comparable to that at AMC: "Community had an old reputation from the 60s, 70s, and 80s that [it was] where we used to bring our old relatives to die" [02S]. Concerns about being linked more closely to Community were also evident in AMC physicians' concerns about feeling pressured to treat patients at Community. One AMC manager revealed, "Physicians who really want to be at AMC don't want to go to Community...This is where they really want to be and they think, 'You're pushing me into a penalty box...I'm a second class citizen'" [12S]. As one Community manager, who was a senior manager at AMC during this time period, revealed, "A barrier has been historically, 'what is the Community identity and purpose within the Family...I don't think we have been clear about it and that, at the end of the day, might be the biggest barrier.'"

In addition to threats to their identities, another part of the problem concerned the considerable ambiguity in the ways in which the relationship between the two hospitals had been defined in the past, which made it difficult to understand how to also interpret the Family identity claim. Of note, many different labels had been used to define the relationship over the years. For example, a local newspaper announced the relationship by stating, "Community looks to expand after *merger* with AMC" [emphasis mine]. Similarly, an AMC newsletter published in 2000 described the relationship as a "*merger* with Community." Yet, a pamphlet produced in

2000 about the history of Community defined the relationship as both a “strategic alliance” and an “affiliation” elaborating further that:

Community Hospital and AMC Hospital signed an *affiliation agreement* forming AMC/Community Hospitals (AMC/C)...[which allows] Community Hospital to achieve its objective of retaining its identity while offering the members of its community a broader choice of many quality services in several convenient locations.

Finally, problematizing activities revealed issues beyond identity: historical relational barriers that prevented managers at both hospitals from seeing themselves as members of “the same Family.” Namely, there had been limited cooperation between managers across hospitals over the years. AMC managers proposed that AMC had been “subsidizing” Community’s operations for years while building new operating rooms at Community even though, as noted earlier, Community’s managers (including Community’s President and CEO) “were doing everything they could to hide behind bushes and just try to keep things the same even though the merger with AMC had happened” [23S]. Community managers suggested that AMC managers had engaged in business practices that were “cannibalizing” Community’s business and “didn’t seem interested in our success” [02FL]. Namely, in 2009, AMC constructed a new suburban ambulatory center that many leaders at Community believed was in Community’s “service area.” As a result, Community managers believed that they were losing patients and were unable to put the new operating rooms to use. AMC managers also felt that Community’s board of directors was uncooperative as well. One AMC senior manager explained:

Community had this big Board and that Board would've died rather than see itself dissolved. The chairs and the other medical staff there who are resisting so much this integration, they would go to the Board and they'd say to the Board, ‘We can't let this happen.’ The Board would buy into it. [25S]

In February 2011, Community’s president and CEO announced in an email communication that he would be “leaving” his position at the end of March.

Organizational identity work: Sorting activities (April 2011 – December 2011). The next set of largely unplanned activities focused on understanding each organization's potential value to relationship, which I refer to as "sorting." Sorting extended from problematizing in that this aspect of identity work assessed each organization's strengths or assets and how they could be used to address the specific problems that had been identified.

Sorting activities started just after the Community president and CEO's departure and was critical for defining each organization's value separately and then within the broader Family context. After Community's president left, AMC's president and AMC's chief operating officer (COO) began spending considerable time at Community in an informal "interim President" capacity. During this time, they engaged and spoke with the remaining members of Community's senior management team and members of the staff in order to design a plan for moving forward. Also during this time, Community was beginning to be positioned as a "Family asset." One Community manager who was a senior manager at AMC during this time revealed:

[The President of AMC/C] understands the value of the community hospital partnership and she is not going to let this asset, which I think she believes is truly an asset, lie dormant. I do believe she thinks it's one of the weapons in her arsenal to compete in the new environment [02S].

In April, an AMC/C Clinical Strategic Planning Committee was formed and co-chaired by AMC's COO and the chief of surgery at Community. Both were long-time members of their respective organizations (the chief of surgery was a member of the group that originally negotiated the merger), which was key for enabling both sides to believe that their perspectives would be well-represented. Membership also included a number of senior managers from the management teams of both hospitals. The Committee was formed as part of a larger AMC/C Clinical Innovation and Care Redesign Process that had started prior to Community's president's departure. Meeting materials stated:

The charge of this AMC/C Clinical Planning Committee is to establish a vision for Community within the context of the greater AMC/C enterprise, and to identify and implement the clinical programs that should be provided at Community.

Thus, the Committee gave the two organizations a vehicle for taking the next steps toward creating value collectively.

One of the first things the Committee did was to take an “asset inventory” at both hospitals in order to identify each organization’s core capabilities. For AMC, the Committee reviewed the clinical services and programs. For Community, the Committee reviewed the clinical services and programs with associated volumes and financials, the physical plant inventory and utilization, “human capital” inventory including physicians on staff, and patient referral patterns and demographics. What they learned was that each organization’s climate was a key enabler in the provision of high-quality care at each hospital. For example, as “political” as many leaders felt the environment at AMC was, the fact that many stakeholders weighed in on processes and initiatives from their inception enabled the hospital to become particularly “data-driven” when assessing patient outcomes. At Community, the environment was described as “friendly” which enabled it to achieve high ratings on patient satisfaction-based measures of quality. Another manager also commented on what was gained from the “asset inventory”:

The reality is that Community is different from AMC and always will be; and AMC is different from Community and always will be. I mean it sounds trite but those are things we should be proud of...We should not want to make [the organizations] one...we need to preserve what’s special [12S].

A critical event during this time was the appointment of a member of AMC’s senior management team as the new chief operating officer of Community. In this role, the COO would serve as the senior most manager at Community but would report directly to AMC/C’s President and AMC’s COO. Thus, Community no longer had its own President/CEO. The new COO was also a member of the Committee and was in charge of quality initiatives at AMC for the previous

10 years. He was also a surgeon by training, which many believed would be helpful for gaining buy-in from physicians at both hospitals going forward.

He revealed what he knew about Community:

I was already very familiar with Community. [My former role at AMC] gave me opportunities to work with the [Community] leadership team probably for the last decade. So I think I [have] very good appreciation for the strengths of the hospital. [Community is] a very strong facility in terms of its quality and safety, its culture around patient satisfaction and patient orientation. So, I think it's a great institution. And yet to me, it's so representative of an opportunity to kind of go to the next level.

Following his appointment, Community's new COO led an initiative in which members of the Committee were surveyed and physicians not on the Committee were interviewed to obtain their perspectives on integration efforts past and future. From these data, the Committee was able to identify the following: "critical factors for successful Community campus clinical program development, relocation, or expansion efforts"; "barriers and obstacles that led to the failure of Community based clinical programs, including those where expansion from AMC was attempted"; opinions on how much "clinical time" physicians practicing on the "Community campus" should spend there; "whether clinical programs at Community should be an extension of programs that are already at AMC...or whether entire programs should be based primarily on the Community campus"; and "the largest barriers to having more AMC physicians eager to practice on the Community campus" (archives).

Organizational identity work: Boundary work activities (August 2011 – October 2012). Once the problems had been identified and the assets catalogued, the two hospitals *deliberately* engaged in boundary work activities to determine how to use both the common and distinct organizational identities to create value for the Family. Boundary work activities entailed putting each organization's assets to use.

From the information gained from sorting activities, the Committee was able to establish clear boundaries for Community's identity within the Family. First, managers thought that Community should have the "quality, reputation, and brand of an AMC, with the convenience, structure, and friendly feel of a community hospital" (archives). In addition, managers thought that the focus at Community should be on "primary and secondary care [since Community's] greatest strength is in [its] ambulatory offerings."⁸ This focus was further elaborated in Committee meetings:

[Community should] serve as the preferred site for secondary general medicine admissions, facilitated by becoming a highly sought after 'partner' for internal and external [primary care practice/physician] groups managing population health and risk (e.g. ACO or global contracts)...Provide state-of-the-art adult primary and secondary care, utilizing a continuum of ambulatory, diagnostic, procedural, and inpatient settings...Serve as the primary location for key AMC/C [Medicine/Surgery] specialty programs that can best be sited on the Community campus, while incorporating Community historic areas of strength. [archives]

One AMC manager explained,

[Community] should be doing the routine community care stuff that we can do very efficiently at a lower cost structure than AMC and those cases that fit that description shouldn't be done at the AMC. They should be done [at Community], which then opens up more capacity at the AMC for presumably higher end tertiary cases which, there, we get paid more [08S].

What then followed was a focus on examining ways to create greater synergy in the relationship between AMC and Community. First, the Committee conducted an extensive evaluation of all of the clinical programs at AMC and Community over a period of four months with a goal of developing "Signature Programs" at Community. From this evaluation, the Committee decided which programs would best support the development and expansion of care

⁸ "Primary care" reflects "day-to-day care" provided by a primary care physician. "Secondary care" refers to both "specialist" care and "acute hospital care." "Tertiary care" refers to "advanced hospital care" usually reserved for the treatment of more complex conditions such as cancer management and advanced surgical care.

at Community. Second, AMC's board and Community's board also agreed to merge at this time by creating a common membership structure. Historically, Community's board had been comprised of individuals who were very loyal to Community, including physicians that practiced at Community and people who lived in Community's service area. AMC's board, in contrast, was a "philanthropic board" comprised primarily of business leaders and large donors. Believing that Community's interests would be considered going forward, many of Community's board members decided to vote themselves off of the board. One former AMC manager working for Community during this time revealed:

[The new COO] has driven significant change in terms of leading the charge with [The President of AMC/C] to get the Community Board to vote themselves out of existence and become one Board now, one Family Board. The same members sit on both the AMC and Community Board so there is no chance of having goals that are not aligned. [Technically, there are] two separate Boards, but they meet at the same exact time and say, 'Okay, this is the AMC meeting. Okay, AMC meeting is dismissed. This is the Community meeting. [08S]⁹

During the second half of boundary work activity, a "rebranding initiative" was conducted based on the interview and survey data which suggested that "aligning the branding of the community hospital with the AMC" would be important going forward (archives). First, a "Brand Advisory Group" was formed and included leaders and members from both hospitals. From December 2011 to April 2012, the Group surveyed and interviewed consumers, referring physicians, and key internal stakeholders. What followed from this research was a recommendation to create a visible identity for the "Family" by naming it "AMC Health Care", change Community Hospital's name to "AMC's Community Hospital," and keep AMC's name

⁹ Essentially, AMC and Community still legally had "separate boards" which was also a requirement given that they maintained separate operating licenses. However, the boards were comprised of the same members. To maintain regulatory requirements, two board meetings were held, but they were held on the same day, and one meeting followed directly from the other.

intact as a “core brand.” Survey and interview participants felt that “Health Care sounds like a larger umbrella...which can include all entities...” (archives). Shortly after this recommendation was made, the Committee, the management teams, and the combined board approved it. A few months later, AMC/C’s President and Community’s COO announced via email to Community employees a plan to rename Community Hospital. Excerpts from the email announcement stated:

For more than 100 years, Community Hospital has met the needs of the surrounding community by offering highly skilled medical care to those in need. This tradition of caring continues stronger than ever with state-of-the-art operating rooms, world renowned physicians, truly exceptional and caring staff, and a wide variety of services expanded over the past 15 years as part of the AMC family.

Today, it is with great pride that we announce that Community Hospital will become AMC’s Community Hospital on October 1, 2012. This new name reflects our ever increasing integration, especially as it relates to our strategic commitments to offer a seamless campus to our patients, to redesign care for maximum efficiency and the best possible outcomes and to create value for patients and payers through our patient affordability efforts....[archives]

On October 1, 2012, a similarly worded email was sent from the president of “AMC and AMC’s Community Hospital” and the COO of “AMC’s Community Hospital (AMCH)” [archives].

Granting new organizational identities. Managers from both organizations largely valued the rebranding initiative; that is, identities were “granted” or socially validated. One senior manager at AMC commented, “It was about time [for the name change]. We should have changed the name a long time ago [but the former President of Community] was very resistant” (29S). Another AMC manager shared, “I think it’s the best of both worlds. I think it’s a community hospital with the academic expertise or consultation right in its backyard” (12S). Despite reluctance to further integrate with AMC in 2010, Community managers generally felt positive about Community’s name change particularly once they perceived that being part of

AMC Healthcare (“The Family”) would ensure continued investment in Community and its patients for years to come. Community’s chief of surgery and co-chair of the Committee revealed, “When our name changed...I was very proud....we're now at a level where AMC considers us good enough to be AMC’s Community Hospital. So you know what? That's what we are.” Those Community managers with mixed feelings about Community’s name change reflected on the loss of autonomy:

I agree with the name change. I think it was an excellent move.... I think the hospital, all the departments are stronger now. There is a loss for autonomy for [Community] unfortunately, but I think you can't have it both ways. [18S]

In this respect, responses to the name changes ranged from pride to resignation.

Phase III: Greater Synergy Is Realized in the Merger Relationship (2012 - 2013)

Once the problems had been identified and the assets were catalogued and put to use, greater synergy was realized in the relationship. Between 2012 and 2013, synergy was realized in two main ways: through the consolidation and standardization of processes and programs and through the utilization of excess capacity. Table 4.5 provides evidence of synergy realization.

Insert Table 4.5 about here

Consolidation and standardization of processes and programs. Increased interaction and cooperation between managers across hospitals enabled them to begin consolidating administrative areas. For example, a joint credentialing process was developed between the two hospitals based on new regulations for “physician credentialing” (i.e., establishing the qualifications of physicians to work in the hospitals). At Community, there was one person designated to oversee the existing credentialing process which was very paperwork intensive and time-consuming. At AMC, there was a larger staff available to manage the credentialing process

but they were using a system that was very different from the one that Community was using. As a result, of the organizational identity negotiation process, the credentialing departments were merged and housed at AMC.

Managers also began standardizing programs across “campuses,” which is how they began to refer to the two hospitals. For example, a vision that arose for Community’s Radiology and Pathology departments during the evaluation of clinical programs in the boundary work phase was to “create an exceptional program with equivalency of services provided at AMC” (archives). As a result, in the Radiology department, imaging equipment, acquisition protocols, exam interpretations, and the information technology infrastructure were all updated to be in accordance with AMC’s standards. Following these improvements, the department saw an increase in its quality and performance measures (archives). Changes to equipment, technical methodology, and processes were also made in the Pathology department to be more equivalent to those at AMC. As a result, turnaround times for results were reduced and fewer issues with quality were reported (archives).

Utilization of excess capacity. By 2013, the total number of patients referred from AMC primary care physicians to the Community ED increased, but both hospitals were still experiencing utilization issues. To offset these issues, the two hospitals began focusing on “Population Management” and creating “Program Centers of Excellence.” For example, the hospitals piloted moving an “inpatient desensitization program” for allergy testing from AMC’s intensive care unit (ICU) to Community’s ICU. This pilot study laid the groundwork for a proposal to establish an allergy skin testing clinic at Community. The management teams also negotiated with more AMC surgeons not currently utilizing the Community operating rooms to schedule their surgeries at Community. As a function of this initiative, the management teams

were also seeking ways to develop more programs at Community to support these surgeons. Several “Centers of Excellence” were also under development at Community to increase both ambulatory (outpatient) and inpatient volume. A “Total Joint Center” for “the Family” was being developed to recapture the volume of knee, hip, and shoulder surgeries and rehabilitation that had been lost to nearby hospitals. A multi-disciplinary “Spine Center” for evaluation of back pain was incorporated into the master plan to attract new patients and physicians.

While synergy realization with respect to consolidation and standardization of processes and programs and utilization of excess capacity showed that progress in the relationship between AMC and Community had been made, managers at both hospitals felt that much more integration work needed to be done to achieve synergy in other ways as well. Community’s COO revealed:

I would characterize the last two years as a super-accelerated integration. We’ve created a joint clinical planning committee and we have the VPs and Chairs from both institutions sitting together at the table...thinking together about what exactly should be done on this campus. And that was really important because in this period of unrest, there were lots of different opinions as to what should be happening from should [Community] be closed to should it be an orthopedic hospital? So, the first thing we had to do was clean that up...we are still committed to the communities we’ve been servicing for 110 years. We are really committed to education and we want to maintain our value. We want to be a really important part of this solution to healthcare reform, which means we have to have great service, great quality at low cost point, cost structure....[So,] we’re working on marketing and branding to have people have a much better understanding of the depth of AMC services that you can get here.

AN EMERGENT PROCESS MODEL OF MULTIPLE IDENTITY RESOURCING AT THE ORGANIZATIONAL LEVEL DURING POST-MERGER INTEGRATION

Inductive research involves moving from raw data, to “themes” or occurrences in this data (open codes) to initial abstractions (axial codes) to the fully theoretical (aggregate theoretical dimensions). Referring back to figure 4.1 (data structure) and following the tenets of inductive research (Spradley, 1979), the case described above is a “descriptive” story of events –

that is a re-telling of the key events that occurred between the two hospitals. In this description, I began to abstract from the data to discuss axial codes. In this section, I move from the data and axial codes to my “aggregate theoretical dimensions:” a further abstraction from data to theory. Figure 4.2 (theoretical model) displays the processual relationships among the key concepts (axial codes and aggregate theoretical dimensions) that emerged from the study that are the basis for a grounded theory of multiple identity resourcing in a merger context. Specifically, the model shows how the negotiation of multiple organizational identities serves as a mechanism that allows managers to manage the tension between unity and distinctiveness in the context in order to realize greater synergy during post-merger integration.

Insert Figure 4.2 About Here

As noted in the strategic management literature, M&As can provide organizations with access to resources that are important for providing them with a competitive advantage as long as these resources are shared (e.g., Stahl & Voigt, 2008). In my study, the original merger agreement was borne out a desire to form a mutually beneficial relationship in which Community could garner key resources from AMC (i.e., patients) and AMC could access critical resources from Community (i.e., space). As a result, the post-merger integration strategy was intended to be “symbiotic” in the sense that specific, albeit limited, resources were supposed to be transferred between AMC and Community (Angwin & Meadows, 2009; Haspeslagh & Jemison, 1991). For a limited period of time, early integration efforts were viewed as “victories” because some resources were shared but new resources were not created.

Yet, the *unmanaged* tension between “becoming one” (i.e., unity) and “remaining separate” (i.e., distinctiveness) led to the emergence of a “preservation” strategy over time, in which managers in each organization began to “defend” their organization from the other by withholding critical resources (Haspeslagh & Jemison, 1991). Specifically, the tension between unity and distinctiveness in the merger relationship between AMC and Community was manifested in two forms initially: in each organization’s desires to form a relationship while also remaining autonomous and in pressures to both integrate and separate operations across the organizations. The lack of attention to managing issues of unity vs. distinctiveness resulted in a failure to share and even generate new resources over time. Hence, integration efforts at large began to fail over time.

My grounded model suggests that the event that triggered problem-solving, active management of the embedded tension, and later integration success was a “common identity claim” in 2010 (i.e., “Family”; Gaertner et al., 1993). It was at this point in time that the tension in the relationship between AMC and Community became constructed as a larger issue about “identity.” As noted in my literature review, identity-based solutions in the context of a merger such as a common identity claim are used for giving organizational members a common referent with which to identify in order to mitigate “us” versus “them” dynamics (Gaertner & Dovidio, 2000; Gaertner et al., 1993). Though not drawing on the common identity model specifically, Clark and colleagues (2010: 427) proposed a similar resolution to the difficulties two top management teams were having “letting go of their existing identities and engaging in the processes necessary to move toward a shared identity.” Yet, in my particular research context, the common identity claim enhanced the threat to distinct organizational identities, one that was already evident and embedded within the context (i.e., threat to AMC’s “excellence” and

Community's "autonomy"), which was problematic for managers from both organizations (c.f., Petriglieri, 2011). In this respect, integrative solutions were too threatening and promoted identity conflict (Pratt, Fiol, O'Connor, & Panico, 2012).

Organizational identity work (Kreiner et al., 2014; Kreiner & Murphy, forthcoming) that was *both emergent and deliberate* played a substantial role in mitigating identity threat (Petriglieri, 2011). Namely, problematizing and sorting out the various identity claims and relational issues and engaging in boundary work to establish both compatibility and complementarity among the different identity claims enabled managers from both organizations to deliberately create a new organizational identity structure that embraced both the common and distinct organizational identity claims. Yet, in contrast to other models illustrating responses to multiple organizational identity claims (e.g., Pratt & Foreman, 2000), managers in this research context used an approach that I call "*inclusion*"—that is, creating two levels of overlap in the naming conventions between the two hospitals by renaming Community, "AMC's Community Hospital" and establishing a superordinate, common, and more "visible" identity to which members of both hospitals could recognize and "grant" (i.e., AMC Healthcare).

Pratt and Foreman's (2000) conceptual framework reveals four managerial responses to managing multiple organizational identities based on the desired level of plurality (maintaining vs. reducing multiplicity) and synergy (creating overlap or separation). Of the four, the authors suggested that the integration response most resembles what happens when two organizations merge and a new organizational identity emerges from the fusion of the two. Yet, the inclusion response in this context resembles the high level of plurality achieved through an aggregation response (i.e., retaining all organizational identities and create links among them, aiming to create high synergy while maintaining high plurality), but the highest level of synergy. Thus, I

propose that “inclusion” maintains the same level of plurality as compartmentalization and aggregation, but the highest level of synergy when compared to the four other responses. Also building on Pratt and Foreman’s theorizing, I propose that an inclusion model was useful in this context because the support by powerful stakeholders for, the legitimacy of, and the strategic value of existing identities was high; resource constraints were high; and the compatibility, interdependence, and diffusion of the different organizational identities salient in the relationship was high.

Ultimately, greater synergy realization was the outcome of organizational identity negotiation, which is consistent with past research on M&As that cites “synergy” as one of the expected, though not easily attained, outcomes of M&A activities (Larsson & Finkelstein, 1999). Here, I draw on Larsson and Finkelstein’s (1999: 3) conceptualization of synergy realization as “the actual net benefits...created by the interaction of two firms involved in a merger or acquisition.” They view synergy realization as “a function of the similarity and complementarity of the two merging businesses (“combination potential”), the extent of interaction and coordination during the organizational integration process, and the lack of resistance to the combined entity” (1). Taking this conceptualization into account, one can perceive that: (1) the common identity claim changed the nature of the conversation between the two organizations (to one about identity rather than resources); (2) that this claim triggered interaction and coordination through organizational identity work that was both emergent and deliberate; (3) that organizational identity work enabled managers from both organizations to create coherence around the combination potential; and (4) the result of this negotiation was the granting of unity and distinctiveness (i.e., inclusion response that signaled a change in organizational names) for

two *dissimilar*, yet, complementary organizations that facilitated cooperation and the sharing of resources by managers across hospitals.

I refer to the entire process as multiple identity resourcing for two reasons. First, it involved conceptualizations of who each hospital was both apart and together, thus it involved multiple identities. Specifically, through both emergent and deliberate identity work activities, managers articulate the meaning behind the AMC, Community, and proposed Family identities and the inherent tension among them. Second, the broader process involved “resourcing” or a process whereby existing resources are used to create new resources (Feldman, 2004; Sonenshein, 2014). Feldman’s (2004) practice-based theory of organizational resourcing draws on structuration theory (Giddens, 1984) to reveal how changes in the internal processes of an organization take one kind of resource and recreate it as a different kind of resource. In this paper, I reveal how a change in organizational names takes organization identities that are valuable to organizational members and makes them an asset for the merger relationship. In this case, existing resources (i.e., legacy organizational identities) were used to create new resources (i.e., new organizational identities, new processes, and new programs) for driving successful post-merger integration. In short, it was through multiple identity resourcing that the hospitals transformed the “unhealthy” tension between unity and distinctiveness in their relationship into one that was much more functional and useful for creating collective value and a more successful integration. Hence, AMC and Community effectively *rebounded* from earlier post-merger integration failure by shifting away from a “preservation” strategy (i.e., one in which resources are withheld from a merger partner) and back to their originally intended “symbiotic” strategy (i.e., one in which resources are shared between merger partners; Haspeslagh & Jemison, 1991).

DISCUSSION

Research proposes that both creating unity and maintaining distinctiveness in the merger context may help organizations that have merged “succeed” (e.g., Stahl & Voigt, 2008). My review of the literature suggested that while this may be possible, such attempts can create tension for managers during post-merger integration. This dissertation draws connections among several literatures to explain precisely how strategists manage this tension at the organizational-level, particularly as it relates to managing multiple and competing organizational identity claims (i.e., statements about “who we are”) and engaging in a process to grant or socially validate new ones. Another contribution of this study is broader process model of multiple identity resourcing during post-merger integration that explains how organizational identities can be used to create valuable post-merger performance outcomes (i.e., greater synergy realization). Finally, in focusing on the activities of “strategists,” this study reveals the specific activities that individuals engage in to create and revise post-merger integration strategy. I elaborate on these contributions and make recommendations for future research below.

Research on Multiple Organizational Identities

Drawing on research on multiple organizational identity management (Pratt & Foreman, 2000), this paper proposes a new managerial response to managing multiple organizational identities in the context of M&As, “inclusion.” Specifically, it reveals the process through which organizations shift from a “compartmentalization” response to an inclusion response, which establishes “optimal distinctiveness” for the merger *relationship*, or a balance between a common identity claim and distinct organizational identity claims (c.f., Brewer, 1991). This inclusion response enabled managers from two hospitals that previously merged to redefine and clarify their relationship to both internal members and external audiences, which allowed them to begin reaping greater benefits from their relationship. As such, I also show empirically how

managing multiple organizational identities matters to performance-related organizational outcomes.

Further, I add to research on multiple organizational identities by incorporating a resource-based perspective on identity that has been used to examine the dynamics of multiple identities at the individual level in organizations (Caza & Wilson, 2009; Creary, 2015; Creary et al., 2015; Dutton et al., 2010; Ely & Thomas, 2001). Specifically, in this study I reveal how organizational identities are enacted in the context as a means of controlling resource flows at the organizational-level. I particularly highlight the role that organizational identity-related discursive practices play in triggering strategic organizational identity-related activities that create new organizational identities and organizational resources. Future research should consider more specifically how identity and resource dynamics at the individual and/or group levels of analysis affect strategy-making in organizations as well.

Research on M&A Performance

Conceptualizing a model of multiple identity resourcing during post-merger integration in this paper adds to research interested in explaining merger outcomes by revealing key merger processes (Clark et al., 2010). Namely, this paper takes an identity-based perspective on explaining M&A performance, which is an underexplored area in research on post-merger integration. Of note, other scholars have used identity theories to explain M&A dynamics (e.g., Clark et al., 2010), but typically, identity dynamics are either described as the “triggers” or the “outcomes” of M&A activities. For example, Clark and colleagues (2010) describe identity ambiguity or lack of clarity about “who we are together” has been described as both trigger and an outcome of M&A activities. This paper is one of the few papers that unveils identity as a mechanism for synergy realization during post-merger integration. As such, an identity lens

helps to open the proverbial “black box” in understanding how to mitigate tensions in the M&A context in ways that also create substantive value for the organizations involved. It also acknowledges explicitly a situation in which post-merger integration performance has varied over time, namely, where organizations with early integration “victories” failed to achieve substantial integration over the long-term, but then managed to *rebound* and achieve greater synergy over time with changes in organizational identity management strategies. Future research might consider other ways in which identity and identity processes explain variability in performance outcomes over time in other M&A contexts including the role of changes in organizational identity management strategies.

This study also adds to the M&A performance literature by highlighting the practices, activities, and practitioners that affect both the process and the outcomes of strategy-making during post-merger integration (Jarzabkowski & Seidl, 2008; Vaara & Whittington, 2012; Whittington, 2007). I particularly respond to scholars calls for more investigations into the strategy-performance nexus (Guérard, Langley, & Seidl, 2013) and more proximal performance outcomes of strategizing at less aggregated levels of analysis (Jarzabkowski & Kaplan, 2015; Jarzabkowski & Spee, 2009; Johnson et al., 2007). For example, past research has investigated success or failure in implementing a strategy (Balogun & Johnson, 2004) and success in pushing a strategic initiative (Lechner & Floyd, 2011) when these strategic activities are deliberate. My study builds on this research by highlighting the variable nature of performance during post-merger integration and viewing performance as both a consequence and an input of both deliberate and emergent strategizing. Namely, past research has revealed that following “early victories” (i.e., periods of success) managers refine their strategies (Greve, 2003). Yet, my study revealed how strategy refinements are not always intended or agreed upon (i.e., claiming a

common organizational identity) which can impede cooperation and lead to negative performance outcomes. As such, in the context of post-merger integration, failure to cooperate can result in failure to integrate even following periods of integration success and the use of deliberate integration strategies. Hence, I propose that emergent strategies can be key triggers for helping organizations to rebound from failure during post-merger integration.

Further, I add to the M&A performance research by revealing how post-merger integration strategy is produced and performed specifically in everyday activities. I particularly highlight the impact of discursive practices (i.e., claims of being a “Family”) on strategy making and post-merger integration practices. Future research should consider more specifically how individual managers perform strategy during post-merger integration and how their strategizing reinterprets and reconstructs the strategy (Jarzabkowski et al., 2007; Jarzabkowski & Kaplan, 2015).

CONCLUSION

In conclusion, M&As are a popular strategy for pursuing growth and innovation. Yet, they are frequently problematic. The results of the present study lend new insights into how strategists manage identity-related challenges in M&A relationships and the impact that different strategies have on synergy realization. Specifically, in the context of mergers and acquisitions (M&As), there are pressures for the organizations involved to be both “similar” and “different.” This paper reveals how managers from two hospitals that have merged manage the tension between unity and distinctiveness and realize greater synergy from their relationship through “multiple identity resourcing.” I invite scholars to continue this line of inquiry by investigating how multiple identity resourcing unfolds in other organizational contexts.

CHAPTER FIVE: SENSEMAKING ABOUT THE MERGER RELATIONSHIP DURING POST-MERGER INTEGRATION

ABSTRACT

How individual managers construct meaning during strategic change is a burgeoning area of scholarship. Yet, managers' interpretations of the change may differ which has implications for how they perform strategy. To date, little insight has been provided on the latter relationship especially in the context of a merger where different conceptualizations of the relationship between two organizations may engender different actions that affect the implementation of an integration strategy. Thus, based on an inductive, qualitative study of two merged hospitals, I reveal how strategy changes influence relational schemas among senior, middle, and front-line managers, which lead to differences in how they manage multiple identities and engage in strategic activities. Ultimately, I introduce a recursive and relational model of meaning construction and strategic change during post-merger integration that highlights the nature of managers' sensemaking about the merger relationship and its role in strategizing. I conclude by offering implications for theory and future research.

How do managers' interpretations of a merger relationship affect how they perform a new integration strategy? From a legal standpoint, the differences between a "merger" and an "acquisition" are arguably subtle (Hogan and Overmyer-Day, 1994). Yet, from a psychological perspective, understandings of "who we are" can differ depending on whether individuals feel that their organization is part of an egalitarian relationship vs. one in which one partner is more dominant (van Knippenberg et al., 2002; Zaheer, Schomaker, & Genc, 2003). For instance, individuals who perceive that they belong to a dominant organization (i.e., a larger, richer, more powerful, and/or influential organization) are more likely to identify with a merged organization since the content of the new merged organization's identity will likely be similar to the content of their pre-merger organization's identity (van Knippenberg et al., 2002). Individuals who perceive that they belong to a more subordinate organization are also likely to identify with a merged organization but that identification may be lower than their identification with their premerger organization (van Knippenberg et al., 2002). In contrast, individuals who perceive that the merger relationship is egalitarian (i.e., one where power dynamics and resource contributions are equivalent between organizations) may be more likely to identify with their pre-merger organization than a new merged organization (Zaheer et al., 2003). Yet, largely missing from research on individuals' post-merger identifications are insights into how managers' interpretations of a merger relationship affect how they perform an integration strategy.¹⁰

In general, research on meaning construction during strategic change proposes that managers construct different meanings about a strategic change (Balogun, Bartunek, & Do, in-press; Balogun & Johnson, 2004, 2005; Bartunek, 1984; Bartunek & Moch, 1987; Sonenshein,

¹⁰ Of note, my emphasis on "performing strategy" draws on a practice perspective on strategy (Jarzabkowski, 2003, 2005; Vaara & Whittington, 2012; Whittington, 1996, 2006, 2007) which acknowledges that strategy is comprised of activities that people "do" (i.e., perform) that can involve "making, shaping and executing strategies" (Whittington, 2006: 619)

2010). Importantly, the ways in which strategic change is communicated among managers has been found to affect managers' sensemaking of change (Gioia & Chittipeddi, 1991). Namely, Gioia and Chittipeddi (1991) found that communicating strategic change in ways that signal a shared vision can create shared schema about the change among managers. In contrast, imposing strategic change on managers without engaging in a more consultative process can create conflicting schema about the change content. Further, different types of meaning-making such as strategy world view and benefits finding can influence individuals' support for the change (Sonenshein & Dholakia, 2012). Yet, it is unclear existing research yields little if any insight into how different types of meaning-making affect the actual making, execution, or shaping of strategy.

I propose that elaborating our understanding of meaning construction during post-merger integration and, in particular, how managers make sense of a merger relationship is important for broadening our understanding of the factors that influence strategy dynamics. Thus, in this paper, I address the question: "How do managers' interpretations of a merger relationship influence how they perform a post-merger integration strategy?" Using a combination of retrospective and real-time data, I examined this research question through an inductive, qualitative field study of senior, middle, and front-line managers from two hospitals, "Community" and "AMC" (both pseudonyms) involved in the implementation of a post-merger integration strategy. Community and AMC had originally merged in 1998 without achieving much synergy. By 2012, senior managers started implementing a new strategy. The bulk of the data used in this study focuses on a 31-month period related to the implementation and later modification of this new integration strategy (January 2012 to July 2014).

In particular, I found that the new integration strategy affected senior, middle, and front-line managers' interpretations of the power and intimacy dynamics in the merger relationship, how they individually managed the multiple organizational identities in the relationship to establish a greater sense of coherence, and how they related to one another during post-merger integration as a result. I then found that these dynamics motivated strategy modification, which also affected managers' interpretations of the merger relationship, their individual management of multiple organizational identities, and their strategizing activities. In this respect, my findings emphasize a relational and recursive model of managers' sensemaking about the merger relationship during post-merger integration that elaborates existing research on meaning construction during strategic change (Balogun et al., in-press; Balogun & Johnson, 2004, 2005; Sonenshein, 2010; Sonenshein & Dholakia, 2012) and research on individual-level responses to multiple organizational identities (Gaertner & Dovidio, 2000; Pratt & Corley, 2007; Pratt & Foreman, 2000; van Knippenberg et al., 2002). In doing so, my research elaborates the central and dynamic role of managers' sensemaking about the merger relationship in managers' responses to strategic change during post-merger integration.

CONCEPTUAL BACKGROUND

The conceptual foundation for understanding meaning construction during post-merger integration originates from research on meaning construction during strategic change (Balogun et al., in-press; Balogun & Johnson, 2004, 2005; Sonenshein, 2010; Sonenshein & Dholakia, 2012) and research on individual-level responses to multiple organizational identities in the M&A context (Gaertner & Dovidio, 2000; Pratt & Corley, 2007; Pratt & Foreman, 2000; van Knippenberg et al., 2002). Here, I review these literatures as they relate to my phenomenon of interest. As such, since this is an inductive, theory-building study, much of the literature I review

in the section that follows became useful and apparent to me as I iterated between data and theory during data collection and data analysis. Therefore, the literature review that follows is an overview of the theories that ultimately framed my research findings (Pratt et al., 2006).

Meaning Construction During Strategic Change

A wide body of research in the field of organization studies is interested in meaning-making during strategic change (Bartunek, 1984; Bartunek & Moch, 1987; Dutton & Dukerich, 1991; Gioia & Chittipeddi, 1991; Gioia & Thomas, 1996; Sonenshein & Dholakia, 2012).

Strategic change involves a “cognitive reorientation” of an organization that often includes a shift in an organization’s purpose, priority, and goals and in individuals’ understandings of the organization (Gioia, Thomas, Clark, & Chittipeddi, 1994). Frequently, senior managers are viewed as the “prime movers” of change (Balogun et al., in-press; Michel, 2014) with senior managers being perceived as the “change agents” and organizational members being perceived as the “change recipients” (McDermott, Fitzgerald, & Buchanan, 2013), though there is some indication in the literature that these roles are flexible (Balogun et al., in-press; Balogun & Johnson, 2004).

Yet, no matter the level in the organizational hierarchy, organizational members can form their own interpretations of strategic change (Balogun et al., in-press; Balogun & Johnson, 2004, 2005; Sonenshein, 2010; Sonenshein & Dholakia, 2012). For example, Balogun and Johnson (2004, 2005) revealed how middle managers made sense of strategic change and developed new interpretive frameworks (i.e., “schema”) about the change. Namely, different situations including the imposition of a new way of working and managers communications with other managers led to different patterns of schema change. As another example, Sonenshein and Dholakia (2012) found that employees are likely to have different interpretations about strategic change based on

the style of communication that is used to communicate change. Namely, managerial communication is more likely than collegial communication (i.e., communication from peers/colleagues) to enable individuals to develop coherence around the need for change and to construct change as having more benefits than downsides.

Drawing primarily on research on sensemaking which is concerned with processes of interaction between individuals and groups (Weick, Sutcliffe, & Obstfeld, 2005; Wrzesniewski, Dutton, & Debebe, 2003) and narrative approaches (Maitlis & Christianson, 2014; Maitlis & Sonenshein, 2010; Sonenshein, 2010), some scholars interested in meaning construction during strategic change have emphasized how relational dynamics shape change implementation (Balogun et al., in-press; Balogun & Johnson, 2004, 2005; Sonenshein, 2010). For instance, Balogun and Johnson (2004) revealed how the change in an organizational structure from an integrated hierarchy to a multidivisional form fragmented one group into three new groups that had to establish new patterns of interaction and coordination. As a result of these relational activities, new patterns of shared yet differentiated sensemaking about the change developed. Similarly, Balogun and Johnson (2005) revealed how the social processes of interaction (e.g., stories, rumors/gossip, sharing of experiences, interpretations, etc.) between middle managers affected their sensemaking about how to respond to a change which led to both intended (i.e., interdivisional liaison and cooperation) and unintended (i.e., interdivisional tensions, protection of turf, disagreements, prolonged “business as usual”) change outcomes.

However, while studies of meaning construction and strategic change have explored how different interpretations of strategic change emerge in an organization through social processes (Balogun & Johnson, 2004) and affect strategy execution (Sonenshein & Dholakia, 2012), they reveal less the impact that meaning-making has on how strategy is made or shaped in the future.

Individual-level Responses to Multiple Organizational Identities in the Merger Context

Identities are key sources of meaning-making in organizational mergers (van Knippenberg & Sleebos, 2006; van Knippenberg et al., 2002; Van Knippenberg & Van Leeuwen, 2001; Van Leeuwen et al., 2003). Importantly, identity is the response to the question, “Who am I?” as an individual or “who are we?” as a collective (Pratt & Foreman, 2000). At the organizational-level, each organization can have its own identity, or conceptualizations about “who we are,” (Corley et al., 2006) and the combined organization can have an identity as well. At the individual level, organizational members can choose to identify with (define themselves in terms of) their premerger organization as well as the combined new organization (Van Dick et al., 2004). Hence, multiple identities at both the organizational and individual levels can co-exist in light of a merger.

Research suggests that multiple understandings of “who we are” can either be beneficial or detrimental and, therefore, may need to be managed (Pratt & Foreman, 2000). Pratt and Foreman (2000) proposed that both the number of organizational identities (i.e., identity plurality) and the relationships among these identities (i.e., identity synergy) can be managed. They categorize four “pure types” of managerial responses to multiple organizational identities: compartmentalization, deletion, integration, and aggregation. Compartmentalization responses preserve all identities in question but do not seek to attain any synergy among them. Deletion responses expunge one or more organizational identities in instances where there is low synergy. Integration responses combine all identities into a distinct new whole to take advantage of synergy while reducing plurality. Aggregation responses retain all organizational identities and create links among them. While this research does not examine the management of organizational identities within the context of merger relationships explicitly, the authors do

suggest that the integration response most resembles what happens when two organizations merge and a new organizational identity emerges from the fusion of the two.

Managing multiple organizational identities can also affect the psychological well-being of organizational members. Pratt and Corley (2007) proposed that in attempts to manage the conflict, uncertainty, and ambiguity arising from multiple organizational identities, there might be unintended negative consequences. Specifically, increasing the number of organizational identities (i.e., identity plurality) may require organizational members to “try to be everything to everyone” (p. 109). Such behavior may lead to psychological distress. However, decreasing identity plurality may provide few alternatives for meaning making, thus making it difficult for organizational members to adapt to new and complex situations, fostering psychological distress as well.

In light of these negative or positive consequences, organizational members may have different preferences for managing their own organizationally-based identifications (or perceptions of oneness or belonging to an organization; Mael & Ashforth, 1992): they may identify with their pre-merger organization and/or the superordinate/ “common” post-merger organization comprised of members from both pre-merger organizations. Relational dynamics also drive these preferences. In some situations, organizational members may acknowledge their multiple social group memberships by identifying with both a premerger and a postmerger organization, which may also help them to feel a greater sense of continuity following a merger (Van Dick et al., 2004).

In many cases, however, individuals choose to identify with only a single organization, which can perpetuate “us vs. them” dynamics in the merger relationship. For example, individuals from a more powerful organization may choose to identify with only their pre-merger

organization when a merger partner is lower in status and they feel that the merger threatens their higher status (van Knippenberg et al., 2002). Individuals may also choose to identify with only their pre-merger organization and not a post-merger organization when their organization is the less powerful partner in the merger relationship and their sense of “who they have been until now” is at stake (van Knippenberg et al., 2002). However, individuals who are members of the more dominant organization in the relationship or those who feel that keeping parts of their identification with their premerger organization is possible are more likely to identify with their pre-merger organization *and* a superordinate post-merger organization (Van Dick et al., 2004; Van Leeuwen et al., 2003).

From this review, we can ascertain that managing multiple organizational identities at the organizational-level can affect organizational members in different ways. Of note, research on individual-level responses to multiple organizational identities has yielded considerable insights on the ways in which individuals manage “who I am” in light of how an organization manages “who we are.” Yet, this body of research tends to focus more on the psychological consequences of organizational identification such as one’s sense of continuity rather than much broader consequences for how they perform strategy work or organizational performance more broadly. In this respect, we do not yet understand how the range of identity responses post-merger affect how strategy is executed, made, or shaped. Understanding the relationship between identity responses and strategy dynamics is important for understanding how organizational members’ attachments to an organization affect how they “do” their work and how, in the doing of work, post-merger integration strategies “fail” or “succeed.”

Hence, in this paper, I build on extant research to pose the following research question: “How do managers’ interpretations of a merger relationship influence how they perform post-merger integration strategy?”

METHODOLOGY

This paper is an inductive, qualitative and longitudinal single case study (Eisenhardt, 1989; Yin, 2009) designed to understand how managers’ interpretations of a merger relationship influence how they perform an integration strategy. Primary data span the period from January 2012 to July 2014. Inductive, qualitative methods are appropriate for at least two reasons. First, qualitative research is appropriate since my research question focuses on *how* something occurs and why it evolves in that way (Creswell, 1998). Notably, process theories explain the sequences of events, activities, and choices that lead to an outcome (Langley, 1999; Langley & Tsoukas, 2010; Mohr, 1982; Pratt, 2012). Process theories are also concerned with how phenomena unfold over time and why they evolve in that way, which can be understood using qualitative theory-building/elaborating techniques. Second, an inductive approach is appropriate since my aim is not to test theory or predict causal relationships, but to build and elaborate theory (Strauss & Corbin, 1990). In theory elaboration, extant theory influences the initial research design (Lee et al., 1999), but the purpose is to “fill in” unknown relationships and processes that may connect existing concepts. Yet for both theory building and elaboration, literature review, data collection, analysis, and theoretical development occur iteratively throughout the research process, contributing to the development of a “grounded theory” (Locke, 2001; Miles & Huberman, 1984; Strauss & Corbin, 1990). Table 5.1 includes a timeline of literature review, data collection, and data analysis.

Insert Table 5.1 About Here

Research Setting and Sample

I initially entered this context interested in multiple identity dynamics in the context of post-merger integration. Therefore, I initially sought a context where identity dynamics would be heightened. After considering a number of context possibilities, I decided that understanding identity dynamics among teaching hospitals in the US that have merged was well-suited to addressing my original research question about how multiple identities are used to create value in organizations during post-merger integration. Specifically, the health care industry in the US as a whole is experiencing “consolidation” pressures due to market forces and changes in reimbursement (Bunton & Henderson, 2013). Therefore, managing identity dynamics is critical for a hospital’s success. However, common to inductive, qualitative research, I became attuned to other dynamics upon entering the context, namely, differences in how managers at both hospitals were interpreting the merger relationship (i.e., as a “merger” or an “acquisition”). Therefore, following Spradley (1980), I revised my focus and research question to be more consistent with the dynamics I was witnessing in the context.

I gained access to Community Hospital [a pseudonym and hereafter, “Community”] and AMC Hospital [a pseudonym and hereafter, “AMC”], two hospitals in the Northeastern United States located approximately three miles away from one another. Community is a 150- bed non-profit community teaching hospital with approximately 1,500 employees and AMC is 793-bed non-profit academic medical center with more than 10,000 employees. Since they first merged in 1998, Community and AMC had been trying to enhance the utilization of patient care facilities

at both hospitals (i.e., patient room occupancy, use of operating rooms) with limited success. Namely, AMC needed more space to treat its patients and Community needed more patients to occupy its space. Yet, by 2010, it was clear that post-merger integration efforts were failing since utilization had not improved substantially over the years. Hence, the hospitals were failing to actively improve resource sharing which was a central strategic goal. As a result, they implemented a new strategy in 2012 designed to improve resource sharing.

I initially used stratified purposeful sampling (i.e., theoretically driven sampling that begins to elucidate the key phenomenon of interest; Miles & Huberman, 1994) based on formal leadership position and organizational membership, and focused specifically on managers who were involved in the development of the new integration strategy. This sampling strategy enabled me to create contrasts and facilitate comparisons within the data to allow for a deeper understanding of the phenomenon of interest and was chosen in light of research suggesting that identity dynamics in the M&A context may differ by level in the hierarchy (Corley, 2004), organizational membership (van Knippenberg et al., 2002), and involvement in strategy development (Corley & Gioia, 2004). Specifically, I worked with a senior manager at Community to create a list of managers at both organizations who were “highly involved” in developing the integration strategy and could share insights on the merger relationship to date. As a result, I initially spoke with a select group of senior managers (i.e., administrative senior executives, chairs and chiefs of clinical/medical services) at Community and AMC.

As my data collection and analysis progressed and themes related to meaning constructions began to emerge, I shifted to theoretical sampling in order to collect data that elaborated and refined emerging categories and themes related to differences in meaning construction and relational dynamics (Charmaz, 2006; Corbin & Strauss, 2008). Namely, I also

began speaking with middle managers (i.e., and directors and executive directors of clinical and administrative departments) and front-line managers (i.e., supervisors, coordinators, and managers of clinical and administrative departments) at both hospitals given insights from the senior manager interviews suggesting that middle and front-line managers were involved in the implementation of the strategy as well.

Data Collection

I used multiple sources of evidence to understand differences in how managers at both hospitals were constructing the meaning of the merger relationship between January 2012 and July 2014 in particular (Yin, 2009). I concentrated on this period in particular since it became evident from my early interviews that the implementation of a new strategy during this time period appeared to be playing a key role in managers' meaning constructions. Using multiple data collection techniques allowed triangulation (i.e., cross-checking data for regularities across sources; Denzin, 2009) and bolstered the trustworthiness of the findings (Lincoln & Guba, 1985). Specifically, I conducted semi-structured interviews as a primary data source and collected archival materials and conducted overt, non-obtrusive observations as a secondary data source. Table 5.2 includes an overview of my data sources including a detailed breakdown of the type and quantity of data per data source.

Insert Table 5.2 About Here

I interviewed 96 managers (senior, middle, and front-line) from AMC and Community and conducted 109 interviews to gain insights into the dynamics in the merger relationship. Thirteen of these interviews were follow-up interviews (i.e., "member checks") with 13 senior

managers to verify that the emergent theoretical framework best explained the dynamics in the research context without doing “undue violence” to the experience of the participants in the context (Pratt, 2000). For each interview, I used a tailored semi-structured interview protocol (per informant type, e.g., physician-manager). The interview protocol for the initial and follow-up interviews included grand (e.g., “Tell me about yourself. What is your role at this Hospital?”) and mini-tour questions (e.g., “What has been your role in the integration process?”) designed to help me understand the merger context including how each informant viewed it and viewed their role within it (cf., Spradley, 1979). Please refer to the Appendices for an example of the protocols.

In addition to interviewing, I obtained 16 years of archival data as a secondary data source (4,012 pages) to offset the retrospective nature of the interviews in detailing the history behind the integration strategy. Archival data include quarterly and annual reports and presentations, newspaper and online reports, organization-wide memos and emails, details of specific projects, employee handbooks, policy manuals, mission statements, and books about the teaching hospitals (Yin, 2009). Senior and middle managers I interviewed gave me access to many of these documents.

Finally, I conducted 450 hours of observations as a supplementary way of understanding what was happening in the context as a consequence of both earlier and later integration efforts. Instead of engaging directly in the work, I took on the role of “observer-as-participant,” which means that I interacted somewhat with those I studied on-site, but the interactions were more casual and passive without interfering with the people or activities under observation (Angrosino & Perez, 2005; Pratt & Kim, 2012). Specifically, I observed strategic planning meetings, leadership meetings, departmental meetings, hospital-wide staff meetings, committee meetings,

patient care areas, morning rounds, and general phenomena in public areas at each hospital. Observations were overt in nature, such that managers and others who interacted with them knew that they were being observed and of my role as a researcher (Whyte, 1984). Over time, observations became more structured as I proceeded with data collection from observing leaders in an “open” manner to developing a more focused observation protocol. This approach allowed me to understand the dynamics between the merged organizations in a general sense and then, more specifically, how meanings about the relationship were constructed in light of the integration strategy. For example, some of the observations allowed me to hone in on the use of the word “merger” to describe the relationship between AMC and Community in several of Community’s departmental and staff meetings which contrasted with the use of the word “acquisition” that several AMC managers used in their interviews. These observations turned my attention to investigating “power schema activation.”

Data Analysis

Similar to Pratt (2000a: 460), I used “within method” techniques (i.e., compared qualitative data across data sources; Denzin, 2009) to triangulate findings from different sources, which enabled me to build stronger assertions about my judgments and interpretations about identity dynamics in the merger relationship. However, common to inductive, qualitative research, I became attuned to other dynamics upon entering the context, namely, how meanings about the merger relationship were constructed and seemed to be influencing identity dynamics. Therefore, following Spradley (1980), I revised my focus to be more consistent with the dynamics I was witnessing in the context, namely, how interpretations of the merger relationship were influencing how managers related and ultimately strategized during post-merger integration.

In an iterative fashion, I employed a theory-building approach and analyzed the interview data by traveling back and forth between the data and an emerging data structure of theoretical arguments (Corbin & Strauss, 2008; Locke, 2001; Miles & Huberman, 1994; Pratt et al., 2006). Archival and observational data were used to cross-check and supplement themes emerging from my interview data analysis. This analysis utilized four major steps (adapted from Pratt et al., 2006):

Step 1: Data condensing. As I collected data, I used several tools including contact summary forms and a field journal to help me capture, make sense of, and condense the data in preparation for more specific data analysis and theory development. This step also enabled me to begin theorizing. The following were some of the data condensing techniques I used.

Contact summary forms. I completed contact summary forms for each interview, observation, and archival document to document the reoccurring topics related to meaning construction and relational dynamics (Miles & Huberman, 1994). Contact summary forms allowed me to consider the main concepts, themes, issues, and questions that were observed during the contact. As such, it was an efficient way to reduce data without losing important details. For example, contact summary forms from June to September 2013 suggested that some managers were viewing the merger relationship as a “merger” while others were viewing it as a “takeover” or an “acquisition.”

Field journal. During all observations and interviews, I wrote notes in a field journal when it was feasible to do so. Real-time journaling allowed me to record my thoughts, reflections, reactions as I was experiencing them (Eisenhardt, 1989). When it was less feasible to write notes in real-time (e.g. it would disrupt the interactions in the context), I wrote or audio-recorded notes using a handheld recording device within 24 hours of the contact. The field

journal contained reflective remarks on ideas that were sparked by observations, interviews, and archival records about data analysis and proposed codes without actually coding the data (Miles & Huberman, 1994). It was important because it helped me to establish some of the most salient dynamics in the context, including the different ways in which managers were interpreting the relational dynamics in the merger relationship. This allowed me to get a holistic sense of the data prior to further analysis.

Step 2: Open coding. In the second stage of data analysis, I coded the “raw” data in the interview transcripts bearing in mind my preliminary theorizing from Step 1. I then identified statements informants made regarding their views of the world to form open codes (Locke, 2001). Next, I reviewed all of the interview data again to see which, if any, fit each category. Finally, I compared across data sources to determine which codes were most relevant. For example, several early data fragments in the interviews suggested that some managers’ were interpreting the power dynamics in the merger relationship in positive ways while others were interpreting them in negative ways or in ways that suggested that they were ambivalent about those dynamics. As I compared these data fragments to others in my memos about “equality/inequality” and “valuing/devaluing”, I was able to develop open codes about “statements about perceiving equality/inequality in the relationship” and “statements about being valued/devalued.”

Step 3: Creation of axial codes. In the third stage of analysis, I integrated open codes to create broader and more abstract axial codes (Corbin & Strauss, 2008; Locke, 2001). Axial codes were compared for similarities and differences in order to clarify relationships that exist between codes (Locke, 2001). Also, at this stage, codes were compared to broader conceptual categories. For example, I compared codes about “statements about perceiving equality/inequality in the

relationship” and “statements about being valued/devalued” to create the axial code, “power schema” (i.e., one of the relational dynamics in the context).

Step 4: Delimiting theory by aggregating theoretical dimensions. At this final stage of analysis, axial codes were considered together in order to understand how the concepts related to one another, so that underling theoretical dimensions could be determined. These theoretical dimensions were then used to form a broad theoretical picture of the data. From this analytical step, I established “relational schema activation and affective interpretation,” “multiple identity management,” and “patterns of relating” as core activities arising from and contributing to the new integration strategy.

FINDINGS

Figure 5.1 summarizes the process I followed and the findings, which shows three main theoretical dimensions that emerged from my analysis (right side of the figure), as well as the axial codes (middle of the figure), and open codes (left side of the figure) that led to the formation of these themes. The three aggregate theoretical dimensions that emerged were new integration strategy; relational schema activation and affective interpretation; multiple identity management; and strategizing activities: patterns of relating. I start by discussing my open and axial codes. In particular, I begin more descriptively by first giving background on the impetus for strategic change, then discussing the new integration strategy that affected individual’s cognitive and affective interpretations of the merger relationship, how individuals individually managed the multiple identities, and, then how these cognitive and affective responses affected individuals’ strategizing activities in the first phase. I then reveal how the strategy was modified in light of what was learned from the first phase, which then triggered another cycle of relational schema activation and affective interpretation, multiple identity management, and strategizing

activities. I conclude this section by proposing an abstract theoretical model that integrates the findings of this paper and builds new theory on meaning construction and strategic change during post-merger integration.

INSERT FIGURE 5.1 ABOUT HERE

Case Overview: The Impetus for Strategic Change

AMC and Community merged in 1998 in order to improve patient care and reimbursement issues at both organizations. The initial strategy was designed to send patients with less complex medical conditions from AMC's crowded emergency department and higher-cost environment to Community's underutilized patient rooms and lower-cost environment. By 2010, integration efforts were failing and both hospitals were continuing to experience utilization issues. One reason for this failure was that many AMC physicians were refusing to send their patients to Community and many of AMC's patients were unwilling to receive their care at Community because they perceived that the care at Community was not as high quality as the care at AMC. A strategic change process was initiated between 2010 and 2012 and culminated in a change in Community Hospital's name to "AMC's Community Hospital" (hereafter, "Community") while keeping AMC's name intact, and renaming the parent organization "AMC Health Care" (hereafter, "Family")¹¹. These name changes were designed to signal to both AMC and Community stakeholders that the two hospitals were "related."

¹¹ "Family" was the term that AMC's president originally introduced in 2010 to describe the superordinate/common identity in the relationship between AMC and Community. After the new names were negotiated in 2012, managers continued to use the word "Family" when referring to the superordinate/common identity.

Yet, by 2012, some AMC physicians and patients were still finding it difficult to view AMC and Community as “related” and were continuing to question whether the quality of care was the same. One AMC executive revealed:

You know patients question whether they want to be at Community. I think some patients find it very convenient as long as their surgeons or their doctors are telling them to go there...But I still think there are still some questions from patients. And some of our [physicians] are very reluctant [to send them there]. [05S]

One Family executive described the AMC physicians’ concerns and the outcomes from raising them:

There was a list of ten things or so that AMC docs who would be the ones sending cases over to Community compiled. They would say, ‘Well wait a minute. You don’t have the type of equipment I want. You don’t have the type of support that I need in terms of someone in the OR with me. You don’t have the overnight coverage that I am comfortable with to round on my patient...’ [08S]

Further, AMC physicians were also questioning whether the physicians at Community were as qualified as they were [archives]. Yet, Community senior managers who were responsible for analyzing the data on the quality of care at Community argued that the care at Community “just as good, if not better” than the quality of care at AMC [10S]. For instance, one Community senior manager stated:

We know our quality and safety is as good as AMC’s, [but] we’re not known to brag. As an institution, we just don’t...and we don’t have the machine behind us to announce what we’ve done and accomplished. [11S]

In light of the negative perceptions and misperceptions about the quality of care at Community, senior managers from both hospitals developed and implemented a new integration strategy intended to change these perceptions. A timeline of key events related to and following the implementation of this strategy is included in Table 5.3.

INSERT TABLE 5.3 ABOUT HERE

Phase 1 Implementation of New Strategy: Physician and Leadership Integration (January 2012 to June 2013)

In 2012, a new strategy was implemented designed to improve perceptions that the quality of physicians and care provided by physicians at Community were similar to the quality of physicians and care at AMC. Driven by a select group of senior managers from both hospitals, this strategy relied on two major activities: senior leadership role alignment and private practice physician integration. Senior leadership role alignment included the creation of new “Family” roles at the senior level and replacement of several division chiefs at Community. First, AMC’s president, AMC’s chief operating officer (COO), and Community’s COO (who was the senior most executive at Community during that time) worked together to create three new integrated “Family” roles at the senior management level: vice president for support services, vice president of finance, and vice president of human resources. Senior managers in these roles were responsible for integrating a number of programs and processes across hospitals or “campuses” (archives) including working with other senior and middle managers to integrate physician credentialing and addressing other equipment and support needs raised by AMC physicians.¹² Integrating physician credentialing would ensure that physicians at both hospitals would be similarly qualified. These roles were viewed as an “experiment” (interviews). For instance, the vice president for support services said the following about her role:

¹² The “credentialing” process is one that establishes the qualifications of physicians to work in the hospitals.

I was the first department leader to cover the same functions at both campuses. So, the challenge is there is can you integrate operations? And to what depth and what level? I'm just starting to get the sense of maybe what the range of possibilities are but this is part of the experiment. [02S]

Physician leadership roles at the senior management level were also aligned to ensure that similar policies and procedures were being used in corresponding clinical departments across campuses and more AMC physicians would both send their patients to Community and begin treating some of their patients at Community. Specifically, a new physician leadership structure was put in place where chiefs at Community started reporting to the chair of their corresponding department at AMC (e.g., the chief of medicine at Community reported to the chair of medicine at AMC). As part of this change, seven of the nine division chiefs at Community resigned. Some of this turnover was fueled by openings created from retirements while other turnover was a function of lack of goal alignment. Some of the physicians who resigned as chief remained at Community.

In addition, a select group of senior managers at Community and AMC also focused on recruiting more Community physicians who were largely independent and private practice-based to join the AMC Physician's Organization (AMCPO). Historically, private-practice physicians provided many of the hospital services at Community through a contractual agreement. However, all AMC physicians were employed and paid by the AMCPO. Differences in the physician employment structure created revenue issues and contributed to perceptions that physicians at Community were not as qualified as physicians at AMC. Thus, having more Community physicians join the AMCPO was intended to address these issues. Namely, Community physicians would become "AMC physicians" which meant that revenue from patient care services at Community would be kept "in-house" and would change how Community's

physicians were “branded.” Many of Community’s private practice physicians decided to join the AMCPO and many of those who did not join did not have their contracts renewed.

Hence, the new strategy in 2012 was focused on ensuring that care provided by physicians at both hospitals was similar as measured by common physician qualifications, common policies and procedures, common infrastructure, and similar support. Additional evidence for the new integration strategy is provided in Table 5.4.

INSERT TABLE 5.4 ABOUT HERE

Phase 1 Relational Schema Activation and Affective Interpretation

Senior, middle, and front-line managers used the new strategy as a cue for making sense of the relationship between AMC and Community, which involved the cognitive activation and affective interpretation of two types of relational schema—power schema and intimacy schema. Power schema reflected cognitive representations of dominance in the relationship, namely, the sense of “equality/inequality” and feeling “valued/devalued.” Intimacy schema reflected cognitive representations of “familiarity” and “closeness” in the relationship.

Interpretations of these relational schemas were also affective. Managers either felt that the dynamics in the relationship created as a function of the new strategy were positive, negative, or both positive and negative.¹³ Those who felt that the relational dynamics were both positive and negative felt positive about the power dynamics and negative about the intimacy dynamics; negative about the power dynamics but positive about the intimacy dynamics; or both positive

¹³ By and large, approximately 10% of the 71 managers in my sample interpreted the power and intimacy dynamics in the relationship associated with the physician and leadership integration strategy as strictly negative (Community managers). Approximately 45% indicated that they felt positive about the dynamics (Community, AMC, and Family managers) and approximately 45% indicated their ambivalence toward them (Community managers).

and negative about the power *or* intimacy dynamics. In general, many of the senior managers from both AMC and Community who were involved in the development of the strategy (i.e., Family executives, AMC managers, and several of Community’s senior managers) felt positive about the power and intimacy dynamics in the relationship. In contrast, other senior, middle, and front-line managers at Community (including several senior managers involved in the development of the strategy) felt either negative or ambivalent about the relational dynamics. I discuss the activation and interpretation of each type of schema and illustrate how it was manifested for different managers. Additional evidence for relational schema activation and affective interpretation is provided in Table 5.5.

INSERT TABLE 5.5 ABOUT HERE

Power schema activation and affective interpretation. Physician and leadership integration made the power dynamics in the relationship salient to managers. Senior and middle managers at all levels and at both hospitals interpreted that AMC was the more dominant partner in the relationship as a result of deeper physician and leadership integration though this dominance was interpreted as either positive or negative. Not surprisingly, AMC managers viewed their dominance positively. This was reflected in statements AMC managers made reinterpreting the original merger relationship as an “acquisition” as opposed to a “merger.” For example, one AMC physician and department chair stated:

I think it actually really was an acquisition with the full asset merger...the way I think of [mergers and acquisitions] as potentially different is based on the asset base of the two parties. I don’t think you can merge a Chiclet with a box of Chiclets. [25S]

A sense of dominance was also reflected in statements AMC managers made about “taking over” services at Community. For example, one AMC executive stated: “The chiefs...oversee the decisions on what kinds of...devices...we’ll place at Community. So we’re taking some of that over” [05S, AMC executive].

Also unsurprisingly, many of Community’s managers viewed AMC’s dominance negatively. For many, the negativity was associated with a sense of powerlessness. For instance, one Community chief revealed, “I think overall, as a medical staff, stand-alone, we’ve lost our independence. We’ve lost our ability to maybe effect changes much” [21S]. One Community chief felt that hiring new chiefs and recruiting private practice physicians to the AMCPO was:

....all about having control, much more control of the money...[One private practice group’s] contract was not renewed, not because of quality, but because AMC wants to get their own...people in here.... [09S]

He also talked about being “pissed off” about AMC’s control in the relationship and that he found it “offensive” that physicians at Community were being branded as “AMC physicians.”

Intimacy schema activation and affective interpretation. The new physician and leadership integration strategy also made the sense of intimacy in the relationship salient to managers at both hospitals. In some cases, the sense of intimacy was manifested in statements managers made about familiarity and closeness in the relationship (or lack thereof) and whether managers felt these dynamics were positive or negative. For example, one Family executive talked about feeling positive about the fact that Community is more of a “part” of AMC as a result of the physician and leadership integration activities. She also revealed that the integration activities made the hospitals seem more “related” and gave an example how the increased closeness was manifested in events at AMC, for example:

I was at the service awards for AMC last week and they were doing the five-ten, fifteen-twenty year awards and they had the year 1998 up and this was the big song, and this

movie won the Academy Award; and Community joined the AMC family...These were VPs doing this...one of them looked over and said, 'Hey, let's hear it for Community.' And there were hoots and cheers and everything from the audience. I thought, 'I'm sure five years ago some people would have reached over and said, 'What's Community?' So, that is what I mean about starting to become part of the fabric that I like to say, 'We are them.' [02S]

Yet, one Community senior manager felt ambivalent about the intimacy in the relationship. She stated:

The integration is a struggle. You know, it is funny because some days I go and I say, 'This is sooo good' and other days it is meaningless to me. I hate to say it. I think I prefer to operate on our own. I don't see a lot of effort or value in involving AMC more because it just doesn't usually add value. I mean, I love AMC, I love everybody there, but I guess I'm done with wasting my time [because] the AMC senior leadership do not think about Community, save a very few....[But] there are some forums where we are represented as The Family...and that's where we need to be more integrated. [11S]

Yet, several other middle and front-line managers at Community felt negative about the lack of closeness in the relationship stating either that "we don't seem to be cohesive" [13E] or "It's AMC taking care of their own" [04E]. One department director talked about feeling "hardened" and "shell shocked" by the changes and a general lack of familiarity with the new chiefs. She revealed:

There are so many new chiefs of service. It's hard to even keep track of it. I keep having to cross the old ones off [the list]. When I came here, the same people were here for decades. That is what made us Community [20D].

Phase 1 Multiple Identity Management

Managers at both hospitals drew on these schemas to manage their own conceptualizations of "who they were." Specifically, managers used their understandings of the power and intimacy dynamics in the merger relationship to individually manage the multiple organizational identities (i.e., Community, AMC, and Family identities). *Multiple identity management* reflected whether managers viewed the content of different organizational identities as compatible or in conflict with one another or with managers' own organizational identification.

Managers individually managed the multiple organizational identities using an inclusionary strategy, an exclusionary strategy, or a filtering strategy. Family executives, and several of Community's senior managers, and AMC managers who felt positive about the power and intimacy dynamics in the relationship used an inclusionary strategy. Senior, middle, and front-line managers at Community who felt negative about the dynamics used an exclusionary strategy while those who felt ambivalent used a filtering strategy. My use of the words "inclusionary," "exclusionary," and "multiple identity management" is consistent with the way these terms have been used in the broader identity management literature (Creary et al., 2015). I discuss the three strategies below. Additional evidence for multiple identity management is provided in Table 5.6.

INSERT TABLE 5.6 ABOUT HERE

Inclusionary strategy. AMC managers, Family executives, and senior managers at Community who felt positive about the power and the intimacy dynamics in the relationship viewed the content of the multiple organizational identities as compatible and synergistic and identified with more than one organization as a result. For example, one of the Family executives who was now working in an integrated role across hospitals revealed, "In my new job, I literally am an integrated person. I am AMC Healthcare" [02S]. For one department director at Community working in a department with a new division chief, managing multiple identities included engaging in activities to continue to develop the content of his AMC identity:

One of the reasons I want to take the administrative certification test is when I go to AMC for meetings, they talk on another level compared to some of our meetings here. It's very chummy and, you know, everyone knows each other. And it's just very academic, very political sometimes and I see the business strategy is more present in all of their meetings. And that's where I think the business background is more of a strength

in that environment...I really need to talk the business talk with my counterparts over there [02D]

For others, viewing the multiple organizational identities as compatible and synergistic was less explicitly about developing content reflective of the different identities, but more about acknowledging what identifying with multiple organizations meant to them personally. For example, one AMC division chair stated:

I have oversight responsibility for all of the [departmental] care that's delivered here and everyone who delivers them. ...so that would include the clinical programs and the....department here and at Community...We're all one big hospital [25S]

Therefore, managers who used an inclusionary strategy did so under the notion that they felt that the content of the Family, AMC, and Community identities was well aligned.

Exclusionary strategy. Unlike managers who used an inclusionary strategy to manage multiple organizational identities, a small group of managers at Community used an exclusionary strategy. These managers were upset by the exit of the Community chiefs and the name change. They viewed the power and intimacy dynamics in the relationship as negative and perceived conflicts in content of the different identities. Hence, these managers all felt more connected to Community as an organization and disconnected from AMC and the Family. As a result, they referred to the different hospitals using “us vs. them” language. For example, one Community chief stated that he was “pissed off” when he saw new marketing material stating that “you can get great AMC care from AMC physicians right in your community.” He further expressed the following:

We need to make sure people remember us, you know? They're saying, ‘We acquired Community.’ No, you didn't. Those of us who have been here this long have worked long

and hard to reverse that line...that people used to come here to die.¹⁴ We have worked long and hard to make those same people say that's my hospital. I don't want to see that compromised. We need to maintain our identity. [09S]

Other managers at Community viewed how they felt disconnected from AMC and/or the Family.

For instance, one Community excluded AMC patients who began receiving their care at Community from Community's identity and grew frustrated when was asked to work on those cases. She stated:

I find myself in this interesting Bermuda triangle of my time, my energy, my money is being caught up solving problems and being yelled at and trying to resolve issues for patients who are not even Community patients. [06D]

The "us vs. them" dynamic was also evident for front-line managers at Community who discussed the conflict in the content of the AMC and Community identities and, particularly, the "friendly" nature of patient care. One revealed:

While we [are treated] like the ugly stepchild that's tolerated at AMC...we've always been very patient-focused and very proud...We always have had to transfer patients [to AMC] for various reasons because our services were limited and our patients didn't then and they, to this day, don't like what they were. If they can, they'd rather be here than go to AMC. I mean, if you're a patient here, everybody interacts with you whether it's the dietary people, the house keeping people, I mean, everyone really does interact [positively] with the patients and the patients feel that difference. [04E]

Filtering strategy. Another group senior, middle, and front-line managers at Community who felt ambivalent (i.e., both positive and negative) about the power dynamics and/or the intimacy dynamics used both an inclusionary strategy and an exclusionary strategy to manage multiple organizational identities. I refer to this as a "filtering strategy" given that these managers 1) viewed certain aspects of each organization's identity content as compatible and

¹⁴ Several managers at both hospitals indicated that there were several negative and well-publicized patient care-related incidents including patient deaths at Community in the 1980s and 1990s. As such, both patients and physicians referred to Community as "the hospital where you go to die."

synergistic, but viewed other aspects as being incompatible and conflicting and/or 2) views oneself as more strongly “attached” to one organization relative to the others. For instance, one Community director who felt ambivalent about the power and intimacy dynamics revealed her struggle to find alignment among the different identities:

Watching Community become AMC’s Community Hospital was very difficult. It was personal when the name changed. Community was a group of people who believed in Community Hospital. When the name was changed and there was someone else telling us what to do, we lost a piece of who we were...I personally took all of these changes very hard because it is personal. It’s who we are. Obviously, it’s who I am and so there came a point in time where I just had to resign myself to the fact that...I have to let it go. I feel like AMC and I are kissing cousins. We have a relationship but we’re different but I don’t want to work for AMC. I want to work here. [21D]

Other Community managers also talked about identifying more with Community relative to AMC or the Family. For instance, one Community senior manager discussed how she did identify with the Family and particularly with her counterpart at AMC, but identified with Community more:

We’re becoming a family and I am accountable to the Family, [but] I represent Community [at AMC meetings]...I was at a meeting at AMC last week and I finally said out loud to the group, ‘I look at the agendas and frankly we never talk about Community.’ The good news is I have a very good relationship with [my counterpart at AMC] and she and I work on discrete issues together. [11S]

Phase 1 Strategizing Activities: Patterns of Relating

My data suggest that managers strategized in different ways based on how they interpreted the power and intimacy dynamics in the relationship and individually managed the multiple organizational identities in the relationship. I refer to these strategizing activities as *patterns of relating*. Patterns of relating in the context include bridging, defending, and complying. Family executives, several of Community’s senior managers, and AMC managers who used an inclusionary strategy used bridging patterns of relating. Senior, middle, and front-

line managers at Community who used an exclusionary strategy used defending patterns of relating. And senior, middle, and front-line managers who used a filtering strategy used complying patterns of relating. These are illustrated next. Additional evidence for patterns of relating is provided in Table 5.7.

INSERT TABLE 5.7 ABOUT HERE

Bridging. Managers at both AMC and Community who used inclusionary strategies to manage multiple identities engaged in activities that were designed to integrate further the two organizations. In addition to deliberately sharing resources between hospitals, many also engaged in activities designed to generate new resources in the relationship (i.e., new programs, practices, policies). One AMC executive talked about his “bridging” activities:

I established a Family...committee so we could continue to review some of these joint programs...We're in the process of planning a very robust total joint center [at Community] with some of our orthopedic surgeons. And that's a collaborative, very collaborative kind of planning process.” [05S]

Bridging activities were also apparent at the middle and front-line managerial levels. Specifically, some AMC middle managers were meeting with their counterparts at Community and vice versa to talk about ways to improve policies, programs, and procedures. Many of these managers were working in departments that had experienced integration as a strategy practice. For example, one AMC director revealed:

I had a meeting with [Community Manager]...It was solely a discussion about Community...Then we started talking about improving and working on our [policies]. What I actually said to her? ‘Why don't I give you what AMC has? Let's see if maybe we can format them in the same way so they're useful regardless of where we are.’ [09D]

Front-line managers at both hospitals were finding ways to share and generate new resources for the organizations particularly new patient volume. One Community front-line manager revealed:

I've reached out to the people that schedule surgeries at AMC. I went with [my manager] to a meeting with them just to be on the same page... We're just trying to let them know that what we do is a little bit different... I put a letter together for them with all of the information that we would need and gave it out and answered any questions they had. [02E]

Defending. In contrast to managers that were sharing and even generating new resources (e.g., new programs) for the organizations, a small group of senior, middle, and front-line managers at Community were finding ways to “defend” Community from the new strategy. Defending refers to challenging integration activities by advocating primarily for oneself/one’s own organization. These managers felt particularly negative about the power and intimacy dynamics in the relationship, and consequently found ways to exclude AMC’s identity from the relationship when managing multiple identities. For some Community managers, defending took the form of challenging integration activities by advocating primarily for themselves and their hospital in meetings with AMC managers at AMC. As an example, one Community front-line manager who felt negative that the two organizations were becoming more intimate stated:

I feel like our presence at AMC is even more expected...it's a good opportunity for us to advocate for what we do at a community hospital level that is often overlooked. [16E]

For other Community managers, defending took the form of arguing against the implementation of new programs, policies, and/or practices. For instance, one Community director whose clinical department was particularly underutilized discussed how she “pushed back” whenever managers at AMC suggested certain improvements be made to her department. She talked specifically about being contacted people at AMC that she did not know and who

informed her that they would be installing new equipment in her department. However, she believed that the equipment would physically interfere with physicians' ability to provide care safely in that space. She stated:

Most of the time, I get an email and I don't even know who the people are. It's hard to know whether I should take this really seriously or just semi seriously....they have been very adamant that we get [this new equipment] and I've been equally adamant that it won't work here because it impacts [patient safety]. [43D]

Other managers, defended Community in private interactions with their colleagues. One Community front-line manager talked about sharing her negative reaction with her colleagues when senior management changed the ICU's name to "FICU" for "Family ICU" as part of the integration strategy for the ICU departments at AMC and Community:

I said, 'FICU? FICU. You can't be changing my name on the ICU.' It sounds like a swear word, doesn't it? Like whose bright idea was that? [04E]

Complying. I refer to the third type of strategizing activity that followed from multiple identity management as "complying." Complying refers to acting in accordance with expectations without actively promoting or challenging integration activities. Community senior, middle, and front-line managers who complied in their strategizing activities neither actively promoted the integration nor defended Community from it. Instead, these managers revealed that they generally did what was asked of them even in spite of having mixed feelings and vacillating in their support of the change because they felt that complying could lead to more positive outcomes. For instance, one Community director discussed how she wanted the relationship with AMC to work but that there were barriers getting in the way. She revealed:

I find that the politics at AMC are different than the politics here and it is harder for me to navigate those waters...a lot of people feel like Community is a small fish in a big sea...and there's a feeling here or sentiment against the staff that sometimes we're an afterthought or if we have a good idea, it's taken and the credit is taken with it...but I

have a cordial relationship with my counterparts over there...It can be challenging at times because I think sometimes they want to change things here to fit the seamless campus philosophy. Then sometimes it doesn't work here and sometimes when we're on board [and] promote the things ourselves, there's push back [from AMC] for one reason or another." [02D]

Another Community director talked about how in her efforts to comply with what was being asked of her as a result of the new strategic practices, she was feeling overworked and like she was not completing her "regular" duties. She stated.

Lately it seems that I'm 90% managing [AMC-driven] projects and 10% doing all the other things so that I'm putting fires out and I'm being reactive rather than proactive. That's never a good feeling." [22D]

Many of the Community managers with whom I spoke who were complying reported that they also felt "overworked" and "burned out." They talked about how they tried to bring this up with their managers, but felt that their concerns were going unnoticed. Many of these managers were considering leaving the organization though some of them indicated that they felt the need to stay for financial and other personal reasons.

Phase 2 Including a Focus on Integrating Hospital Departments (June 2013 to July 2014)

While activities related to physician and leadership integration were useful in improving some of the negative perceptions at AMC about the quality of Community physicians and their care, it had not been effective in increasing collaboration between other clinical and administrative hospital departments at Community that also played an important role in patient care. Thus starting in June 2013, the strategy was modified to include activities designed to integrate these other departments as well. In contrast to the activities focused on physician and leadership integration, the activities centered on hospital department integration were co-

developed by senior and middle managers from both hospitals—particularly those who had been bridging previously. Importantly, activities related to hospital department integration were not a substitute for those focused on physician and leadership integration; rather, activities related to physician and leadership integration continued.

Similar to the activities in Phase 1, the activities in Phase 2 had an impact on relational schema activation and affective interpretation, multiple identity management, and strategizing activities/patterns of relating. I discuss these below.

Phase 2 Relational Schema Activation and Affective Interpretation

The power and intimacy dynamics in the relationship continued to be salient to managers at AMC and Community. Power schema continued to reflect the sense of “equality/inequality” in the relationship but also included a sense of “valuing/devaluing”. Managers at all levels and at both hospitals continued to interpret that AMC was the more dominant partner in the relationship. Similar to Phase 1, managers at AMC viewed the power dynamics that transpired during this phase positively while managers at Community viewed them positively, negatively, or ambivalently. For example, senior and middle managers across both hospitals developed and implemented new policies, procedures, and programs in some of the departments that were designed to make those departments operate more similarly to their counterpart at AMC/Community. Frequently, AMC’s policies, procedures, and programs were adopted at Community. One Community director expressed that he felt positive about these developments and explained his rationale:

We’re trying to adopt some of the programs AMC has...I think that the change has been exceptionally positive. I know that there were times prior to these changes where we were really struggling. I remember going to the leadership meetings and I would listen to the financial reports because we were always losing money...we’re certainly in the

positive and that gives you a different perspective when you come in to work on a daily basis so that you know you may not get a pink slip today because we are doing a little better. [36D]

Other managers at Community were explicit about feeling “valued” as a result of the resources they were gaining from hospital department integration. One front-line manager at Community stated, “[AMC is] helping us to get the better equipment...the communication is good” [05E].

Yet, several Community front-line supervisors working in these departments perceived that they were “slowly being overtaken [by] the big house” [13E]. Several used the term, “AMC-ized” to describe how they perceived the influx of changes to policies, procedures, and programs at Community. For example, one Community front-line manager stated:

We’re AMC-ized. A lot of their policies and procedures have been brought over here. Sometimes it’s annoying because they think that just because it came from AMC that theirs is the best way. They don’t realize that sometimes people at Community did things a lot better. [17E]

Also salient were intimacy schema reflecting the sense of “familiarity” and “closeness” in the relationship. Similar to the power dynamics, managers at AMC viewed the intimacy dynamics that transpired during this phase positively while managers at Community viewed them positively, negatively, or ambivalently. For instance, one AMC manager expressed that he felt positive about the influx of AMC-related people, policies, practices, and programs at Community:

Community has been under the AMC umbrella for 15 or so years but we really haven’t pushed the connection until the past couple of years...So every time a director or some position of that nature becomes available, they see whether they can combine efforts with Community. We treat them just like another off-site building right now, an annex of AMC. They’re no different. Five years ago, I would never have said that....Community is an extension of AMC. We have the same policies. We have the same philosophies. We have the same healthcare practices and we have the same human resource systems, payroll systems, information systems.” [34D]

Yet, these same dynamics created for many Community managers a negative sentiment about the lack of familiarity with the new AMC physicians who were beginning to treat their patients at Community. For example, one Community front-line manager talked about this as a lack of familiarity with the AMC physicians and why this was problematic:

All of a sudden, we didn't know who these doctors were that we were working with. And just about the time you'd get a clue as to who they were, how to interact with them best, what their capabilities were, their strengths, where we had to watch out, where they might need a little nudge or extra help, they've gone. So, it's just this constant battle. [04E]

Hence, activation and affective interpretation of power and intimacy schema continued with the additional focus on hospital department integration.

Phase 2 Multiple Identity Management

Managers at both hospitals continued to draw on relational schemas to manage the multiple organizational identities using an inclusionary, exclusionary, or filtering strategy during Phase 2. Similarly, Family executives, and several of Community's senior managers, and AMC managers who felt positive about the power and intimacy dynamics in the relationship used an inclusionary strategy. For instance, as a function of the focus on hospital department integration, one AMC director became the director for that department across campuses. As a result, he identified with Community, AMC, and the Family. He spoke about this and how he displayed and managed his multiple identities:

I'm also a Family guy. I'm responsible for anything that has the Family label on it....I identify with all of the facilities....but my paycheck comes from AMC. I do have two [identification] badges. Who am I today? [*shows me his Community identification badge*]. [09D]

Senior, middle, and front-line managers at Community who felt negative about the power and intimacy dynamics during Phase 2 used an exclusionary strategy to manage the

multiple organizational identities. One Community department director continued to view the Community and AMC identities in terms of “us vs. them” since she perceived that they were not well-aligned:

We’re a community hospital. But now, even our meetings have changed. They used to start out with [a director] talking about a really heartwarming tear-in-your eyes story of helping a patient. And now, they are more focused on clinical excellence, cost efficiency and using data from the employee satisfaction survey to better the efficiency of your department...It seems more like AMC....They’re leaders in research and technology...people come from all over the world to go to AMC...[but] I just loved this place when it was [just] Community. People knew every other person. People knew intricate details about the hospital and remembered when....People really took the time to engage with other people who worked here. People were really happy here....Nobody is really sure what our new identity is. [20D]

Finally, senior, middle, and front-line managers at Community who felt ambivalent about the power and/or intimacy dynamics during Phase 2 used a filtering strategy. For these managers, there was still the sense that certain identities were sometimes compatible and synergistic while at other times those same identities were fundamentally in conflict with one another. For example, one Community director stated:

Community is a big part of who I am...I stay late when I have to. I do what I need to do...but AMC is a big part of me too lately, more recently...If you would have asked me that question about AMC two or three years ago I probably would have said less....but it’s almost like we’re losing our identity slowly over time and now we’re a puppet of AMC. [22D]

Phase 2 Strategizing Activities: Patterns of Relating

How managers interpreted the power and intimacy dynamics in the relationship and individually managed the multiple organizational identities continued to influence their patterns of relating in Phase 2. For instance, Family executives, several of Community’s senior managers, and AMC managers who felt positive about the power and intimacy dynamics in the relationship used an inclusionary strategy and bridging patterns of relating. For example, an AMC director

revealed how she was continuing to integrate her department's operations with those in a corresponding department at Community:

Currently, we've undertaken an effort to upgrade our safety reporting system to a new version. All of that work is completely joint with the folks over at Community. The project specialist who manages the system over here has been more than willing to help out and do whatever is needed at Community. [The Director at Community] and I have gone back and forth around how great it is that we have that wonderful working relationship. [38D]

In contrast, senior, middle, and front-line managers at Community who felt negative about the power and/or intimacy dynamics used an exclusionary strategy and defending patterns of relating during Phase 2. For example, one Community director shared how she raised concerns in a leadership meeting about having to address complaints from AMC patients receiving their care at Community even though her department managed patient complaints at Community:

I did a presentation in the leadership meeting yesterday on where we stand with the breakdown of complaints. A lot of the private practices are AMCPO run. I explained that they should really go through the AMC Patient Relations office...[Those practices] are not even part of us.¹⁵ They're tenants. [06D]

Finally, Community senior, middle, and front-line managers who felt ambivalent about the power and/or intimacy dynamics in the relationship used a filtering strategy and complying patterns of relating during Phase 2. One Community front-line manager struggled with the good and bad (e.g., the political dynamics but also feeling "taken over"):

There's been a lot of good from the affiliation with AMC. There's been a lot of growth [with] different patient populations coming in for care, but I think that AMC has slowly been taking over the different areas within this hospital that will be solely used for what

¹⁵ The Patient Relations office is where patients go or who patients contact when they have concerns about the quality of their care. When AMC physicians started seeing more of their patients at Community, it was unclear who "owned" the problems that these patients were having with their doctors—the AMC Patient Relations office or the Community Patient Relations office.

their needs are. Perhaps they might let us have a little bit of autonomy maybe. I don't know if there would be that much. However, I'm very dedicated to Community. I've been here so long. It's a huge part of who I am and I'm committed to steering us in a direction that is a positive way to go. [13E]

SENSEMAKING ABOUT THE MERGER RELATIONSHIP DURING POST-MERGER INTEGRATION

Referring back to figure 5.1 (data structure) and following the tenets of inductive research (Spradley, 1979), I used the previous section to move from occurrences in the data (open codes) to discuss axial codes. In this section, I move from axial codes to my “theoretical dimensions” to further abstract from data to theory. Figure 5.2 (theoretical model) displays the theorized relationships among the axial codes and aggregate theoretical dimensions that emerged from the study and are the basis for a grounded theory of strategizing. Specifically, the model shows how managers' sensemaking about the merger relationship affects strategic change during post-merger integration. Notably, how new strategy practices used to manage resource dynamics in the relationship affected the cognitive activation and affective interpretation of relational schema related to power and intimacy dynamics in a merger relationship, which affected how managers managed their own conceptualizations of the multiple identities at play and resulted in different types of strategizing behavior at the individual-level.

As noted in the literature concerned with individual level responses to managing multiple organizational identities in the merger context, individuals can respond very differently to mergers especially when power and status dynamics in the relationship become salient (van Knippenberg et al., 2002). In my study, AMC's dominance in the relationship became more apparent over time particularly once a new strategy was implemented in response to the growing concern at AMC, the larger and higher-status organization, that the existing relationship with

Community, the smaller and lower-status organization, was not meeting their needs. As a result, managers at AMC withheld resources (i.e., patients) from Community. This behavior was problematic given that the ultimate “success” of this merger relationship was defined by its ability to exchange and even generate new resources (i.e., patients for patient care space and vice versa). Subsequently, a new strategy was implemented to facilitate greater resource exchange.

What followed were several different types of sensemaking responses that revealed the impact that the new integration strategy was having on managers’ understandings of “who we are” and, subsequently, how they performed the integration strategy. Namely, managers at both hospitals responded to the new strategy and its later modification in three different ways. One group of AMC and Community members who had previously felt as if the two organizations were “unrelated,” felt that the two organizations were becoming increasingly “close” and perceived this increasing sense of intimacy as positive. Positive perceptions of intimacy in the relationship triggered identity work in the form of an inclusionary strategy. Specifically, those managers at AMC and Community who felt empowered by the new strategy felt *secure* in their multiple identities or that different organizations were self-defining and that they were comfortable being a member of all of them (Pratt et al., 2012). They viewed the multiple organizational identities as aligned, synergistic, and compatible, and, consequently, these managers used an inclusionary strategy to manage the multiple organizational identities and developed a self-narrative that was consistent with this experience of enrichment. As such, an integrative and inclusionary strategy was one pathway for creating a more integrated and positive sense of self in the context of strategic change (Creary et al., 2015; Dutton et al., 2010; Roberts & Creary, 2011). Bridging was the relational outcome for managers who perceived alignment between themselves and the broader goals of the merger relationship. AMC managers who

bridged exhibited greater cooperation and resource sharing in their interactions with members of Community. Further, “bridgers” also led later strategy modification efforts, which was effective in integrating other clinical and administrative departments that also affected patient care.

In contrast, a different group of Community managers felt that the sense of closeness between the two organizations perpetuated the sense of unfamiliarity among members of the two organizations. They also felt overpowered by AMC’s dominance in the relationship and, as a consequence, felt disempowered and devalued particularly when their input on the change was not sought out or welcomed. Further, the Community identity was relatively strong for many of these managers. In other words, Community’s identity was self-defining for them and they felt proud of their membership in that organization (Pratt et al., 2012). Thus, these managers managed the multiple organizational identities and created a more positive sense of self by utilizing an exclusionary strategy. They viewed AMC’s identity as inconsistent and incompatible with their own sense of self and excluded the AMC identity from their self-conceptualizations. As a result, these managers defended Community in their interactions with those who were trying to facilitate the integration or in their conversations with peers at Community.

Finally, yet another group of managers at Community felt ambivalent about the increased intimacy in the relationship and AMC’s power. As a result, these managers felt uncomfortable or insecure in their multiple organizational memberships. They used a filtering strategy to manage their multiple organizational identities, viewing the organizational identities as compatible and synergistic in some respects but as in conflict with one another in other respects. Hence, these managers vacillated in their sense of coherence and conflict and struggled to create a positive sense of self in the context of strategic change. Complying was the outcome for these managers who desired alignment between the two organizations, but perceived that there would be or

currently was a cost to attaining this goal—often personal. Hence, many of these managers also experienced a drain of personal resources (Hobfoll, 1989).

Ultimately, the emerging model of sensemaking about the merger relationship during post-merger integration makes several important claims. First, meaning construction during strategic change has both cognitive and affective dimensions and understanding both is important to understanding the different ways in which organizational members respond to strategic change. Further, affective responses are not simply positively or negatively; they also reflect ambivalence. This finding contrasts with past research on meaning construction during strategic change which primarily characterizes meaning-making by its cognitive components and differences in cognitive responses by managerial level (Balogun et al., in-press; Balogun & Johnson, 2004) or organizational membership (van Knippenberg et al., 2002).

Second, broader relational dynamics especially from the standpoint of power and intimacy in a merger relationship do play a substantial role in how managers respond to strategic change, make sense of a merger relationship, and perform an integration strategy. I found that managers who felt more positive about the relational dynamics in merger relationship were more likely to make, shape, and execute the new strategy. In contrast, managers who felt more negative about the relational dynamics were less supportive of the new strategy, though they did not always “resist” its implementation out rightly. This finding stands in contrast to past research on strategic change which suggests that individuals with negative meanings of change frequently “resist” change (Sonenshein, 2010). Of note, Sonenshein (2010: 496) labeled a negative response to change in which employees were threatened by the change as “resisting.” These employees were described as “subverting the change, such as reducing work effort or raising objections to new practices.” In my study, managers who felt negative about the change certainly raised their

objections, but they did not necessarily reduce their work effort or actively try to subvert the change. Further, managers with both negative and positive meanings of change (i.e., ambivalence) actually ultimately complied with the change.

Third, meaning construction can not only affects the *execution* of the strategy at hand, but can also affect the characteristics of the change itself. Specifically, managers who engaged in bridging activities to share and grow resources between the two hospitals also succeeded in modifying the strategy a year and a half later. Past research on meaning construction during strategic change typically views strategy change as a one-time event (Balogun et al., in-press; Balogun & Johnson, 2004, 2005; Sonenshein, 2010; Sonenshein & Dholakia, 2012). In contrast, my findings suggest that strategy changes activate relational schemas among senior, middle, and front-line managers, which lead to differences in how they manage multiple identities and engage in strategic activities and that this process is iterative. As such, my emphasis on the recursive nature of meaning making during strategic change enhances our understanding of the conditions under which strategies “succeed” in organizations.

Overall, my theoretical story suggests that 1) relational dynamics are key to meaning construction during strategic change, not just in terms of the power and status dynamics, but also in terms of the intimacy dynamics in the relationship; 2) these relational dynamics affect identity dynamics at the individual-level (i.e., how managers’ manage multiple identities); 3) and that strategic change and meaning construction is iterative and recursive.

DISCUSSION

Past research proposes that organizational members’ own cognitions and actions can influence the “success” of strategic change (Balogun et al., in-press; Sonenshein & Dholakia, 2012). This

study draws connections between two disparate literatures—research on meaning construction and strategic change and research on individual-level responses to multiple organizational identities—to explain these relationships. Another contribution of this study is a recursive and relational model of meaning construction and strategic change during post-merger integration that explains the different pathways leading to different forms of strategizing in a post-merger integration context. I elaborate on these contributions and make recommendations for future research below.

Meaning Construction During Strategic Change

While past research makes it clear that organizational members' interpretations and actions no matter their level in the hierarchy are important to the “success” of strategic change initiatives (Balogun et al., in-press; Balogun & Johnson, 2004, 2005; Sonenshein, 2010; Sonenshein & Dholakia, 2012), missing from this literature is attention to identity dynamics at the individual-level in the context of strategic change and the role that they play in how individuals construct meaning and act on strategic change. In this paper, I build on extant research on meaning construction during strategic change to reveal how identity dynamics at both the organizational and individual-levels have an impact on managers' sensemaking about the merger relationship and strategizing behavior. Specifically, I reveal how new strategy practices make power and intimacy dynamics in the relationship particularly salient. Managers' reactions to these relational dynamics influence their identity management at the individual level, which influences the particular type of strategizing behavior in which managers engage during post-merger integration.

Yet, it could be the case that managers' interpretations of relational dynamics in a merger relationship during strategic change shift and change over time. As such, a potentially

interesting direction for future research would be to capture managers' cognitions and emotions and different periods of time following the implementation of new identity-altering strategic practices. Findings from this type of study could potentially lend insight into the longitudinal nature of meaning construction during strategic change (Balogun et al., in-press) and how these patterns shift and change over time including any triggering events/activities.

Multiple Identity Management in Organizations

Conceptualizing a recursive and relational model of sensemaking about the merger relationship during post-merger integration adds to research interested in the antecedents to and outcomes of multiple identity management in organizations (Creary et al., 2015; Pratt & Corley, 2007; Pratt & Foreman, 2000; Ramarajan, 2014; Rothbard & Ramarajan, 2009; Terry, 2001; Van Knippenberg & Van Leeuwen, 2001). Namely, this paper reveals how implementation of a new strategy has consequences for individuals' interpretations of and actions during strategic change. Of note, other scholars have revealed the impact of managing multiple organizational identities on individuals (Pratt & Corley, 2007), but this research does not reveal how individuals reinterpret the relationships among multiple identities or the affect that these interpretations have on their strategy-making endeavors. Specifically, I find that relational schema activation and affective interpretation of those schema play a critical role in determining how multiple organizational identities are managed at the individual-level. This finding elaborates existing research on individual level responses to managing multiple organizational identities in the merger context by moving relational dynamics front and center in our theorizing about multiple identity management. In this respect, I suggest that relational dynamics are both an impetus for and an outcome of multiple identity management. Future research might consider whether different forms of multiple identity management at the organizational-level (Pratt & Foreman,

2000) lead to different interpretations of relational dynamics and different relational dynamics in general at the individual-level following strategic change.

CONCLUSION

In conclusion, implementation of a new strategy may be important for fostering greater synergy in the context of a merger. Yet, strategy implementation can have consequences for organizational members' own cognitions and actions in ways that may or may not support merger goals. The results of the present study lend new insights into the central role of managers' sensemaking about the merger relationship in strategic change during post-merger integration. I invite scholars to continue this line of inquiry by investigating how relational dynamics affect strategizing in other ways.

CHAPTER SIX: DISCUSSION AND CONCLUSION

INTRODUCTION

Taken as a whole, this dissertation set out to examine how organizations and their members *rebound* from failure during post merger integration. Drawing from prior work on M&As, strategy-as-practice, multiple identity management, identities as resources in organizations, and meaning construction during strategic change, I examined the actions and experiences of individuals involved in post-merger integration strategizing; the deliberate and emergent nature of strategy work that affects individuals and organizations over time; and how strategizing contributes to organizational-level episodes of success during a long-term post-merger integration process.

Using the merger of an academic medical center and a community teaching hospital as my empirical setting, I examined the conditions and mechanisms that contributed to periods of success and failure during post-merger integration between 1998 and 2014. My analysis consisted of two empirical chapters that employed qualitative techniques: Chapter Four examined the processes and practices that a group of senior and middle managers from both organizations used to share existing resources (i.e., patients and patient care spaces) and generate additional resources (i.e., programs) for the two organizations, following a period of integration stagnation; and Chapter Five revealed the different ways in which individual managers' meaning constructions affected the ongoing success of strategic change. Table 6.1 provides a summary of the major findings and contributions from each of the empirical chapters. In this chapter, I discuss more broadly how these studies relate to each other and provide directions for a future research agenda that builds on the findings of this dissertation.

Insert Table 6.1 About Here

Observations Across the Empirical Studies

When I began this dissertation, I was motivated to understand how multiple identities are used to create value in organizational life. I have long been intrigued by the idea that multiple personal, social, and role identities are sources of meaning and action for individuals at work and that they can be valuable in the broader context of organizational life. Yet, I have learned that people respond in different ways to the coactivation of multiple identities. For example, some individuals experience conflict whenever two or more identities become salient in a situation while others find this phenomenon enriching. Much of the past research in the field of organizational studies focuses on the conditions that contribute to identity conflict and how such conflict is managed. As such, I believed that examining the conditions under which multiple identities enrich individuals and their organizations would contribute to our scholarly understanding of identity dynamics in organizational life and would foster greater insight into the conditions that promote thriving, flourishing, and generativity in organizations more broadly. As such, I sought a research context in which multiple identity dynamics would be heightened (i.e., a merger relationship).

As I became immersed in my research context and began to collect and analyze data, I realized that I had been focused in large part on “the answer” to a question without clear insight into what was that larger question that multiple identity dynamics were intended to address. Hence, my most important discoveries came from stepping back and saying, “What is really going on in the context and why are people behaving and reacting in these ways?” Over time, I

learned that the coactivation of multiple organizational identities in this context was a consequence of and a catalyst for strategic change and the consequences were multi-level. The acknowledgment of the multi-level nature of the phenomenon required me to not only take a multi-theoretical perspective but to also adjust my methodological approach. As such, the findings of this dissertation truly emerged from an inductive and iterative process. I now step back to examine the connections between my two studies more holistically.

I believe that one of the most interesting discoveries in this dissertation is that organizations can and do rebound from failure during post-merger integration. Yet, departing from more traditional economic and financial definitions of merger performance in the broader M&A literature, I characterize “success” and “failure” in terms of a more proximal outcome measure of “synergy realization” (Larsson & Finkelstein, 1999) and in terms of “what people do” with strategy practices at the individual-level (i.e., how individuals “perform” strategy; Jarzabkowski et al., 2007; Vaara & Whittington, 2012). What I learned was that “taking social practices seriously” was key to understanding how these outcomes were achieved (Vaara & Whittington, 2012). Heretofore, I use the “praxis, practices, and practitioners” conceptual framework used widely in the field of strategy-as-practice research (Jarzabkowski et al., 2007; Whittington, 2006) to help organize my findings across the two studies as they relate to “successful performance” at both the level of the merger relationship and the level of strategy implementation.

Jarzabkowski and colleagues (2007: 9) defined *praxis* as “the interconnection between the actions of different, dispersed individuals and groups and those socially, politically, and economically embedded institutions within which individuals act and to which they contribute.” This definition recognizes that praxis is embedded and operates at different levels of analysis,

which is aligned with my findings in Chapters Four and Five. Specifically, in these chapters, I reveal the convergence of actions that senior managers, middle managers, and front-line supervisors take to affect strategic change within the context of a long and protracted post-merger integration. Activities related to organizational identity negotiation were triggered in large part by the external environment—namely, national and political discourse related to improving the affordability of health care in the US and the implementation of new policies that were pressuring hospitals and other health care institutions to engage in cost-saving measures. Managerial activities at both the individual- and collective-levels were designed to reconcile “who I am/we are” and were embedded within organizational-level strategic change. I expose this embeddedness in both chapters. In Chapter 4, managers collectively engage in organizational identity work to bring two organizations closer together and successfully share and generate resources (i.e., patients, space, new programs). In Chapter 5, how managers individually make sense of the relationship and the multiple organizational identities in the relationship, affects how they perform (i.e., make, execute, and/or change) strategy. In this respect, successful strategy implementation entails cycles of strategy making, execution, and change activities.

I also discuss the *practices* that actors draw upon and shape praxis. Reckwitz (2002: 249) defined practices as “routinized types of behavior which consist of several elements, interconnected to one another: forms of bodily activities, forms of mental activities, ‘things’ and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge.” In this respect, practices provide resources through which actors act and interact when engaged in praxis (Jarzabkowski et al., 2007). In this dissertation, multiple practices influence praxis and produce new practices. At the organizational-level, AMC

president's discourse around "family" was a routinized behavior that triggered organizational identity work (i.e., *problematizing*, *sorting*, and *boundary work* activities) and, subsequently, the development of a new strategic practice—new naming conventions. New naming conventions triggered the development of another strategic practice—a new integration strategy comprised of leadership integration and physician integration. A "healthy" balance of strategy making and execution at the individual-level enabled not only implementation of the physician and leadership integration strategy, but also implementation of a modified strategy that also emphasized hospital department integration that was successful for the merger relationship.

Finally, I discuss the *practitioners*—those individuals who draw upon strategy practices to act. The findings in Chapter Five that focus specifically on individual behavior directly addresses a central issue in the field of organizational studies and social theory more broadly; that is, how structure and agency link together to explain action (Bourdieu, 1990; Giddens, 1984; Vaara & Whittington, 2012). Namely, managers use a new integration strategy as a cue for interpreting the power and intimacy dynamics in the merger relationship, the nature of multiple organizational identities, and directing their strategy implementation work: "bridgers" make the strategy and help to change it; "compliers" execute the strategy and help to maintain it; "defenders" problematize the strategy and help to shape it. Hence, this dissertation reveals pathways through which practitioners construct and engage in activity that leads to successful strategy implementation.

From this discussion, I hope to have conveyed the *social practices* grounded in and emerging from multiple identity management and meaning construction more broadly that enabled two organizations that have struggled to integrate over a long period of time to rebound from post-merger integration failure. I would be remiss, however, if I did not mention that this

“success” was at a cost to Community and that the tension between unity and distinctiveness, though “managed,” remained “unresolved.” In this case, it is clear that tensions are inherent in organizational life and that what is good for “a relationship” (i.e., resource sharing and generation) may not always seem the most positive from the perspective of an individual organization or manager.

DIRECTIONS FOR FUTURE RESEARCH

I am excited about the new questions that this dissertation research raises. My dissertation investigates identity dynamics at multiple levels of analysis and cross-level identity dynamics. In this respect, I respond to a call for greater attention to between level dynamics in the field of organizational studies (Ashforth, Rogers, & Corley, 2011). Specifically, I examine the interplay between organizational identity and resource dynamics at the organizational-level and among relational dynamics, organizational identity management at the individual-level, and strategic change at the organizational-level. Notably, an emerging resource-based perspective on identities in the organizational studies literature helps us understand the value that identities at the individual-level hold in organizational settings (Caza & Wilson, 2009; Creary, 2015; Creary et al., 2015; Dutton et al., 2010; Ely & Thomas, 2001). Creary and colleagues (2015) examine specifically the relationship between multiple identity management at the individual-level, resource dynamics, and relational quality. To this end and in the spirit of cross- and multi-level theorizing, future research could examine more closely the interplay between identity and resource dynamics at the organizational-level and identity and resource dynamics at the individual-level. In particular, scholars could examine what *multiple identity resourcing* would “look like” at the individual-level. Under what conditions would multiple identity resourcing at the individual-level be valuable for individuals? For their organizations?

Further, in focusing on praxis, practices, and practitioners, my dissertation takes a comprehensive approach to examining strategy-making in organizations. In so doing, I reveal connections between these three different social practices and how they constitute one another within the context of strategic change. I examine all of this with attention to multiple identity management which responds to a call to connect “who strategists are and what they do” more explicitly (Jarzabkowski et al., 2007: 27). Future research should explore the links between strategy-making and identity management at different levels of analysis. For example, future research could explore how the management of other role- or socially-based identities affects strategy practices and strategic change and how strategy practices and strategic change influence the management of other role- or socially-based identities (i.e., theirs or others). For instance, do managers with multiple professional identities (e.g., physician-managers) make, execute, or shape strategy differently from managers with more singular professional identities? Do these two groups of managers experience strategy making and strategic change similarly? Further, how do managers with different socio-demographic identities (i.e., gender identities, racial/ethnic identities, etc.) make, experience, and/or shape strategic change? How do managers as intermediaries who are dealing with their personal tensions of distinctiveness, power, and intimacy shape others’ identities during strategic change? Examining identity dynamics at the level of the individual and how they relate to strategy making and strategic change could also broaden our understanding not only of “who strategists are and what they do,” but *how* strategy work is done.

Finally, this dissertation invites scholars to consider more broadly a typical and rational strategy frame of resources and competitive advantage in explaining firm-level outcomes. Namely, Barney (1991) argued that firms sustain a competitive advantage from controlling both

tangible and intangible resources that are valuable, rare, imperfectly imitable, and not substitutable. In this dissertation, the resources of concern (i.e., patients, space, new programs) were definitely valuable, though arguably rare, imitable, and substitutable. Drawing on more organizational-level theories of identity (e.g., Pratt & Foreman, 2000) and resourcing (Feldman, 2004) enables us to focus less on defining what constitutes a resource, however, and more on explaining their mutability and utilization. In Chapters Four and Five, for example, I reveal how *cognitive and emotional attachments* (i.e., identities) affect resource flows in organizations, which is an explanation that the existing strategic management literature currently does not offer. As such, organizational-level theories of identity and the findings of this dissertation can be used to counter more rational perspective on strategic management, which often portrays organizationally life as intentionally planned and constructed. Further, my emphasis on “resourcing” calls attention to arguments that resources are not fixed in organizations – that can be generated and even exploited in context with action (Feldman, 2004; Glynn, 2000). Future research should continue to examine the non-rational and non-planned side of strategic management, which could potentially yield a fuller and more accurate perspective on organizational life.

CONCLUSION

Giddens (1984) asserted that phenomena only become resources when they are constituted in social practices that account for both the roles and the analysis of structure and agency. The story of the long and protracted post merger integration process between AMC and Community is one story of how multiple identities become and are used as resources in the context of strategic change. My findings suggest that social practices in the external environment trigger social practices at the organizational- and individual levels of analysis that

make the most of the multiple organizational identities reflected in the broader merger relationship. I am excited about the broader research program on multiples identities, resources, and strategic change that this dissertation has inspired and the opportunity to contribute to multiple and disparate avenues of scholarship.

TABLES

Table 3.1: Overview of Data Sources for the Dissertation

Description of Data	Quantity	Dissertation Chapter
<i>Semi-Structured Interviews</i>		
- Senior managers including administrative senior executives, chairpersons and chiefs of medical/clinical services, and clinical program directors	31 individuals, 45 interviews (average: 45 minutes per interview)	- Chapter Four (primary) - Chapter Five (primary)
- Middle managers including directors and executive directors of clinical and administrative departments	45 individuals, 45 interviews (average: 1 hour per interview)	- Chapter Four (20 primary) - Chapter Five (primary)
- Front-line supervisors, coordinators, and managers of clinical and administrative departments	20 individuals, 20 interviews (average: 45 minutes per interview)	- Chapter Five (primary)
- Former managers	4 individuals, 4 interviews (average: 45 minutes per interview)	- Chapter Four (primary)
	Total: 100 individuals, 113 interviews between June 2013 and July 2014	
<i>Archival Documents</i>		
- Annual reports and presentations, newspaper and online reports, organization-wide memos and emails, details of specific projects, employee handbooks, policy manuals, mission statements, and books about the hospitals	4,012 pages from between the years 1998-2014	- Chapter 4 (primary) - Chapter 5 (secondary)
<i>Overt, Non-Obtrusive Observations</i>		
- Strategic planning meetings, leadership meetings, departmental meetings, hospital-wide staff meetings, committee meetings, patient care areas, morning rounds, public areas	450 hours between June 2013 and July 2014	- Chapter 4 (secondary) - Chapter 5 (secondary)

Table 4.1: Timeline of Data Collection and Analysis for Development of Grounded Theory on Multiple Identity Resourcing

Time Period	Literature Review	Data Collection	Data Analysis
	Identification of theoretical gap Interest in “multiple identities as resources” prompts study		
June to November 2013		Initial interviews: 15 senior managers/executives and 5 middle managers Archives: Collection of internal and public source documents about the merger and integration to date Observations: 13 hours on and off-site at strategic planning and general leadership meetings	Initial data reduction analyses: Review of field notes, contact summary forms, and memos from data collected during this period suggest tension around “unity” and “distinctiveness” in the context Triangulation: Compare data from different sources to build stronger assertions about my judgments and interpretations Coding: Developed preliminary open and axial codes from interview and archival data Peer debriefing to meet methodological and theoretical credibility criterion

December 2013 to July 2014		<p>Initial Interviews: 16 senior managers/executives, 15 middle managers, and 4 former managers</p> <p>Follow-up Interviews/ “Member checks”: 14 senior managers/executives to meet theoretical credibility criterion</p> <p>Archives: Collection of internal and public source documents about the merger and integration to date, including records from Community’s library; secured strategic planning documents from Clinical Strategy Committee</p> <p>Observations: 437 hours on site at a variety of meetings and events</p>	<p>Analyses: Review of field notes, contact summary forms, and memos from data collected during this period suggest importance of “Family” claim to identity dynamics in the context and using “multiple identities as a resource”</p> <p>Triangulation: Compare data from different sources to build stronger assertions about my judgments and interpretations</p> <p>Coding: Continued to develop open and axial codes from interview and archival data; constructed main theoretical dimensions</p> <p>Peer debriefing to meet methodological and theoretical credibility criterion</p>
July 2014 to May 2015	<p>Returning to the literature: Refinement of core puzzle. Iterating between theory and data to refine emerging theory and process model</p>		<p>Analyses: Refinement of open and axial codes and aggregate theoretical dimensions. Combined with iteration between theory and data reveals data structure that suggests the concept “multiple identity resourcing” to describe the overall dynamics in the context.</p> <p>Triangulation: Compare data from different sources to build stronger assertions about my judgments and interpretations</p> <p>Peer debriefing to meet methodological and theoretical credibility criterion</p>

Table 4.2: Overview of Data Sources for Chapter 4

Description of Primary Data	Quantity	By Organization	
		AMC	Community
<i>Semi-Structured Interviews</i>			
- Senior managers including administrative senior executives, chairpersons and chiefs of medical/clinical services, and clinical program directors	31 individuals, 45 interviews (average: 45 minutes per interview)	18 individuals, 21 interviews	13 individuals, 23 interviews
- Middle managers including directors and executive directors of clinical and administrative departments	20 individuals, 20 interviews (average: 1 hour per interview)	3 individuals, 3 interviews	17 individuals, 17 interviews
- Former managers	4 individuals, 4 interviews (average: 45 minutes per interview)	1 individual, 1 interview	3 individuals, 3 interviews
	Total: 55 individuals, 69 interviews between June 2013 and July 2014	22 individuals, 25 interviews	33 individuals, 43 interviews
	Quantity	By Organization	
		AMC	Community
<i>Archival Documents</i>			
- Annual reports and presentations (shared)	1,238 pages	--	--
- Newspaper articles about the merger	26 pages	--	--
- Online reports and emails	259 pages	52 pages	207 pages
- Organization-wide memos	70 pages	5 pages	65 pages
- Details of specific integration projects (shared documents)	1,152 pages	--	--
- Employee handbooks	300 pages	n/a	
- Policy manuals	315 pages	200 pages	115 pages
- Mission statements	2 pages	1 page	1 page
- Books about the hospitals	650 pages	n/a	n/a
	Total: 4,012 pages representing the years 1998 to 2014		

	Quantity	By Organization	
		AMC	Community
<i>Overt, Non-Obtrusive Observations</i>			
- Strategic planning meetings		--	16 hours
- Leadership meetings		--	75 hours
- Hospital-wide staff meetings		--	15 hours
- Committee meetings		--	50 hours
- Departmental meetings		--	40 hours
- Patient care areas		--	50 hours
- Morning rounds		--	15 hours
- Public areas		42 hours	147 hours
	Total: 450 hours between June 2013 and July 2014		

Table 4.3 Representative data for the tension between unity and distinctiveness

Themes	Representative Data
<p><i>Pressures to Unify</i></p> <p>Wanting a mutually beneficial relationship</p>	<p>“We tried to avoid the word ‘merger’ at the beginning [in 1998, but] at that point, we shared the same corporate bottom line and we moved by agreement patients back and forth between the two hospitals... We were two separate hospitals with a joint mission mutually supporting each other to the benefit of both.” [24S, Community division chief]</p> <p>“By the time the 90s came, all the hospitals were pairing off... we merged with AMC....[The former AMC CEO]’s concept for this system was sort of typified by the comment, ‘providing the right care at the right place at the right cost.’” [10S, Community senior manager]</p> <p>“We needed patients...they needed a community hospital rotation for their residents and had an incredible surplus of patients. AMC was the best option for us....They had what we need, which was patients. And the fit was a very good fit.” [09S, Community division chief]</p>
<p>Wanting to maximize Community’s resources</p>	<p>“Community provided us with an instantaneous [operating room availability], room availability, community environment, easier setting to get into, while at the same time, my space at AMC was saturated.” [17S, AMC division chair]</p> <p>“We want to be better and in [1998] we had lots of volume...and so [we thought] wouldn’t it be neat to have another hospital and a hospital in the ideal world where patients with pneumonia or patients with secondary care could go?” [12S, AMC senior manager]</p> <p>“we had a lot of general medical patients sitting here—ninety percent of those people did not need to be at a tertiary medical center. So we needed to move them to Community...” [16S, AMC senior manager]</p> <p>“Community was a troubled community hospital with a shrinking volume, a negative operating statement, and a lousy balance sheet...from our perspective, it was a way to acquire real estate without trying to build more here without the overhead.” [25S, AMC division chair]</p>

<p><i>Pressures to Remain Distinct</i></p>	<p><i>e.g., Wanting to maintain “who we already are”</i></p> <p>“The institutions, at least by statute initially, had to maintain two separate boards and bed control and certificates of need by the state were specific to the institution...they weren’t viewed as one unified institution. And there were also organizational differences between the two that, at some level, were advantageous to maintain. So for example, there are two nurses unions and with different rates; so if they were a consolidated union, clearly the rates would have gone to the max rate...taking away the low-cost advantage.” [30S, AMC division chair]</p> <p>“The was at the time a lot of angst...here because the physicians were concerned that we were going to get swallowed up by this AMC monster, that we’d been competing with them for a long time, how could we possibly let them into our door?” [09S, Community division chief]</p> <p>“People’s biggest fear was that Community wouldn’t be known as a community teaching hospital. It was going to be known as AMC South or AMC West.” [03F, Former Community senior manager]</p> <p><i>e.g., Wanting to keep “doing things the way we’ve always done them”</i></p> <p>“In an ACO world, Community becomes a huge asset....that patient could go to Community, get the care they needed, and we can get a lower return but, on the other hand, we would also be saving the health care system money. But in a fee-for-service world, we are constantly going back and forth as to what should we do with Community...the fact that we still look at how we maximize our revenues across the system [puts] Community at a disadvantage.” [13S, AMC senior manager]</p> <p>“Integrated will not occur until the external environment forces it on us. So, until we truly go to a system where we own all our own patients, and our dollars are our dollars, and put them where they are best cared for, and it is the best thing for them, for the system, everybody else, it won’t happen.” [11S, Community senior manager]</p>
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Table 4.4 Representative data for organizational identity negotiation

Themes	Representative Data
<i>Common organizational identity claim</i>	<p>i.e., <i>Being a “Family”</i></p> <ul style="list-style-type: none"> - [The new AMC president] came. New person comes, new kid on the block...she wanted us to be a family.” [27S, AMC senior manager] - “[The new AMC president] wanted to align the branding of the community hospital with the AMC as a family but also [wanted to align] the governance because we had two separate boards and we were doing needless work.” [29S, AMC senior manager]
<i>Organizational identity work</i>	
Problematizing	<p>e.g., <i>Defining competing identity claims</i> [Internal documents, websites, and annual reports]</p> <p>“What we do”</p> <ul style="list-style-type: none"> - AMC: “International Leader Pioneering Breakthroughs”; “The Most Complex Cases” - Community: “Patient Friendly Environment...Compassionate Care”; “Commitment to Quality and Personal Attention” <p>“Our history”</p> <ul style="list-style-type: none"> - AMC: “Legacy of Excellence” - Community: Commitment to the Community <p>“Our mission”</p> <ul style="list-style-type: none"> - AMC: “Transform the future of healthcare, through science, education, and compassionate care, locally and globally” - Community: “Excellence in patient care services, provided in a learning environment with dignity, compassion, and respect” <p>e.g., <i>Deciphering the identity threats</i></p> <ul style="list-style-type: none"> - “There was a point in time where people said the care wasn’t that good at Community....you know, you hear one bad story and you’ll never forget it. The physical plant is different...The optics from a prestige perspective may come into play a little bit....Community isn’t as fully equipped as AMC. They don’t have the depth and richness of staff and supplies and latest technology and all of that.” [12S, AMC senior manager]

Sorting

e.g., Generating an idea to create value collectively

- “[At Community, we can] create a center that is a national leader in minimally invasive [gynecological] surgery (MIGS) focused on the most advanced procedures and cost-effectiveness in a patient-friendly and surgeon-friendly environment...[we can] leverage Community’s smaller size to manage a rapidly changing field while maintaining excellent quality, patient satisfaction and cost-effectiveness.” [archives]

e.g., Identifying core capabilities and complementarities

- “Community has easy parking, better parking...It is clean. It is easy...You have a question to ask and get an answer right away. We pride ourselves on being friendly. It’s so nice.” [02S, Community senior manager]

- “AMC brand is a draw for patients and provides a comfort level....Spending time practicing at AMC helps physicians to maintain a level of credibility, also helps to provide ‘cross fertilization’ of knowledge” [archives]

Boundary work

e.g., Establishing identity boundaries

- “Community is an asset that represents real value for us because it allows us to grow certain lines of business, but which we cannot grow here. It’s more likely than not a lower-cost setting, so we may be able to compete more effectively for certain business that’s (leaning) the academic setting. And I think quite frankly there are certain parts of our clinical portfolio that should be delivered out there....a big chunk of like our outpatient business can be delivered out there, should be delivered out there.” [05S, AMC senior manager]

e.g., Creating opportunities for synergy

- “we have a unique opportunity to ensure that our care is of the highest quality, seamlessly coordinated and always patient-centered...[We can] intensify our patient/family-focused approach to care to measurably improve satisfaction and engagement; measurably improve the efficiency of our care delivery and reduce costs across our distributed campus and network; leverage our experience as leaders in patient safety and quality systems to define the most meaningful measures and to excel in our performance on these measures; continue to use our expertise and culture of innovation to set new

standards and milestones in health care delivery.” [CSC archives]

Granting new organizational identities

“Community just brings such value to us and to the community. I mean, if you look at their clinical outcomes, it is so impressive. They provide expert care in a community setting. So, you know, the fact that we have put our name over the front door really says a lot about our faith and that we are proud to be associated with that organization. We’re not seeing that as a liability to our brand. We’re actually seeing Community as a value add to our brand....we shouldn’t call them Community anymore. It should be AMC’s Community Hospital and we should be AMC. Together we are AMC Healthcare.” [06S, AMC senior manager]

“I think the name change has impacted patient’s perception. We say it’s the same AMC doctors. We’re AMC’s Community Hospital. I think that has been a positive change.” [16D, Community middle manager]

Table 4.5 Representative data for synergy realization

Themes	Representative Quotations
<i>Consolidation and standardization of programs and processes</i>	<p>“We’ve moved to similar and similar processes. We want AMC and Community to have similar systems in place so that it all works the same way...” [20S, AMC senior manager]</p> <p>“Developed joint quality, compliance, credentialing insight” [Strategic planning slides, archives]</p> <p>“New Community by-laws, with common Community-AMC-AMC Healthcare Boards” [Strategic planning slides, archives]</p> <p>“Integrated [private physician group] practice into AMC physicians’ organization” [Strategic planning slides, archives]</p> <p>“Integrated [two centers] into a single comprehensive program for clinical operations, marketing and development” [Strategic planning slides, archives]</p>
<i>Utilization of excess capacity</i>	<p>“Shifted 500 AMC cases to Community and began service in [neurological] center and primary care.” [Strategic planning slides, archives]</p> <p>“Continued growth of secondary admissions from AMC primary care groups” [Strategic planning slides, archives]</p> <p>“% AMC [primary care practice] admits up to 49%; # AMC [primary care practice] admits increasing while AMC ED transfers stable; 228 AMC [private care patients] in January [2013] highest ever” [Strategic planning slides, archives]</p> <p>“Shifting a portion of Dr. [name]’s AMC operating room volume to Community” [Strategic planning slides, archives]</p>

Table 5.1: Timeline of Data Collection and Analysis for Development of Grounded Theory on Sensemaking about the Merger Relationship During Post-Merger Integration

Time Period	Literature Review	Data Collection	Data Analysis
	Identification of theoretical gap Interest in “multiple identities as resources” prompts study		
June to November 2013		Initial interviews: 15 senior managers/executives and 5 middle managers Archives: Collection of internal and public source documents about the merger and integration to date Observations: 13 hours on and off-site at strategic planning and general leadership meetings	Initial data reduction analyses: Review of field notes, contact summary forms, and memos from data collected during this period suggest that managers’ meaning constructions of the merger relationship differed Triangulation: Compare data from different sources to build stronger assertions about my judgments and interpretations Coding: Developed preliminary open and axial codes from interview and archival data Peer debriefing to meet methodological and theoretical credibility criterion

December 2013 to July 2014		<p>Initial Interviews: 16 senior managers/executives, 15 middle managers, and 4 former managers</p> <p>Follow-up Interviews/ “Member checks”: 14 senior managers/executives to meet theoretical credibility criterion</p> <p>Archives: Collection of internal and public source documents about the merger and integration to date, including records from Community’s library; secured strategic planning documents from Clinical Strategy Committee</p> <p>Observations: 437 hours on site at a variety of meetings and events</p>	<p>Analyses: Review of field notes, contact summary forms, and memos from data collected during this period suggest importance of relational dynamics to meaning construction</p> <p>Triangulation: Compare data from different sources to build stronger assertions about my judgments and interpretations</p> <p>Coding: Continued to develop open and axial codes from interview and archival data; constructed main theoretical dimensions</p> <p>Peer debriefing to meet methodological and theoretical credibility criterion</p>
July 2014 to May 2015	<p>Returning to the literature: Refinement of core puzzle. Iterating between theory and data to refine emerging theory and process model</p>		<p>Analyses: Refinement of open and axial codes and aggregate theoretical dimensions. Combined with iteration between theory and data reveals data structure that suggests a relational and recursive model of meaning construction during strategic change</p> <p>Triangulation: Compare data from different sources to build stronger assertions about my judgments and interpretations</p> <p>Peer debriefing to meet methodological and theoretical credibility criterion</p>

Table 5.2: Overview of Data Sources for Chapter 5

Description of Primary Data	Quantity	By Organization	
		AMC	Community
<i>Semi-Structured Interviews</i>			
- Senior managers including administrative senior executives, chairpersons and chiefs of medical/clinical services, and clinical program directors	31 individuals, 45 interviews (average: 45 minutes per interview)	18 individuals, 21 interviews	13 individuals, 23 interviews
- Middle managers including directors and executive directors of clinical and administrative departments	45 individuals, 45 interviews (average: 1 hour per interview)	7 individuals, 7 interviews	38 individuals, 38 interviews
- Front-line supervisors, coordinators, and managers of clinical and administrative departments	20 individuals, 20 interviews (average: 45 minutes per interview)	2 individuals, 2 interviews	18 individuals, 18 interviews
	Total: 96 individuals, 109 interviews between June 2013 and July 2014	27 individuals, 30 interviews	69 individuals, 79 interviews
Description of Secondary Data	Quantity	By Organization	
		AMC	Community
<i>Archival Documents</i>			
- Annual reports and presentations (shared)	1,238 pages	--	--
- Newspaper articles about the merger	26 pages	--	--
- Online reports and emails	259 pages	52 pages	207 pages
- Organization-wide memos	70 pages	5 pages	65 pages
- Details of specific integration projects (shared documents)	1,152 pages	--	--
- Employee handbooks	300 pages	n/a	
- Policy manuals	315 pages	200 pages	115 pages
- Mission statements	2 pages	1 page	1 page
- Books about the hospitals	650 pages	n/a	n/a
	Total: 4,012 pages spanning the years 1998 to 2014		

	Quantity	By Organization	
		AMC	Community
<i>Overt, Non-Obtrusive Observations</i>			
- Strategic planning meetings	16 hours	--	16 hours
- Leadership meetings	75 hours	--	75 hours
- Hospital-wide staff meetings	15 hours	--	15 hours
- Committee meetings	50 hours	--	50 hours
- Departmental meetings	40 hours	--	40 hours
- Patient care areas	50 hours	--	50 hours
- Morning rounds	15 hours	--	15 hours
- Public areas	189 hours	42 hours	147 hours
	Total: 450 hours between June 2013 and July 2014¹⁶		

¹⁶ As a function of the new strategy, the primary activity related to the merger occurred at Community vs. AMC. During interviews, I checked with managers at both AMC and Community to understand whether I should observe specific meetings, etc. held at Community, but I was told that the events at Community were not frequently discussed at AMC.

Table 5.3: Key events leading up to and following the implementation of the new strategy

Timeframe	Event
1998	Community and AMC agree to merge. Form parent company. Retain separate boards, administration, medical staff, financial reporting systems, and licenses
1998 - 2008	Integration of AMC and Community medicine and surgery residency programs. AMC's Foot and Ankle Center (ambulatory) moved to Community. Start of Community 500 initiative focused on moving less complex patient cases from AMC's ED to a patient room at Community. New operating rooms constructed at Community. Several AMC ambulatory clinics expand services to Community.
2010	New President and CEO hired at AMC. Characterizes the relationship as a "Family."
2011	President of Community resigns and is replaced by senior manager from AMC who assumes a COO role at Community.
2012	Community's name is changed to "AMC's Community Hospital," AMC's name remains the same, and the parent company is renamed "AMC Healthcare."
January 2012 – June 2013	New integration strategy is developed and implemented - targeted towards leadership role integration and physician integration.
June 2013 – July 2014	Strategy is modified and implemented - targets integration of other clinical and administrative departments

Table 5.4 Representative data for new integration strategy

Themes	Representative Data – Phase 1 (Jan 2012 – Jan 2014)	Representative Data – Phase 2 (Jan 2014 – July 2014)
<i>Leadership Integration</i>	<p>“I reported to the Support Services vice-president at AMC. That person left that position at that time. The Support Services director at the Community was also Support Services Vice-President of clinical operations over there also. She had a dual role. So what the administration here did is decompress some of her role at Community and have her take on the responsibility of Support here at AMC. So at that point, I started reporting to her. She was the VP of Support Services at the Community at the time and now she's also VP of Support Services here at the AMC.” [34D, AMC Middle Manager]</p> <p>“I mean I have had a pretty clear mandate to make sure that [physician] leadership is AMC leadership. So have made two chief changes this year in [one medical division] and [in another medical division], but [there were] docs who were honestly not interested in cooperating with AMC, in those two areas. So I asked them step down as Chief. They are here, but they are not in a leadership role. So I actively work with the AMC [division] to make this a seamless department so that all the counterparts under me...work cooperatively with the divisions AMC.” [01S, Community Chief]</p>	<p>“It's an interesting challenge to be asked to impart a vision on a place that you have never set foot in because these interviews are most of them actually were at AMC and a couple of evenings at restaurants and things like that...[but] I think what has gone really well is [that I've helped] blow down the silos. The laws of geopolitics as you know are profound and I think I mentioned that and everybody [in my medical division] was all over the place in this hospital. Now, we're on [one] floor I think that's really helpful for the coalescing the department.” [26S, Community Chief]</p> <p>“The AMC [medical division chief] decided that our director should not continue as a director. Although he stepped down, it was a -- he was not at the end of his career...he had been in this department for a long time....he's done a great job of trying to revamp things as things have changed significantly with AMC [intervention] and he just hasn't been able to maintain that.” [10D, Community Middle Manager]</p>

<p><i>Physician Integration</i></p>	<p>“You know the AMC surgeons wanted AMC anesthesia and AMC surgeons wanted AMC pathology if the were doing cancer or breast [surgery] or so. And so they wanted the same level of care and the same standards. Everything to be is almost AMC-ized as possible.” [28S, AMC Executive]</p> <p>“We brought [Community physicians] into the PO where we could have just actually replaced them, but we wanted to bring them in. We’re not here to take things over and disrupt everything.” [28S, AMC Executive]</p> <p>“I remember when I first started the Chief sort of pulled me aside and said, ‘You can go to AMC meetings but we’re just going to do our own thing.’ Those were his words. Now, the new Chief is a former Chief at AMC.” [19D, AMC Manager]</p>	<p>“...we now have virtually all of our faculty understand that they’re going to work at AMC predominantly, that they’re going to do some urgent care shifts which definitely is not what they signed up for, and some Community-ships...so much has happened across the landscape or across the country that everybody understands this.” [25S, AMC Chair]</p> <p>“We went from the Nuc Med exams being done at Community and being read by a Community radiologist to the Nuc Med exams being done at Community and read by an AMC radiologist completely cutting out our group of 12 radiologists. I think the group felt that financially a little bit....We had nuclear medicine experts working at AMC. We do not have nuclear medicine experts working at Community.” [19D, AMC Manager]</p> <p>“...now it's ninety percent plus of the medicine staff are actually AMC employed docs that just work here. That is true on the inpatient side. That's true on the outpatient side. So there is very few staff who don't have AMC training or an AMC connection.” [01S, Community Chief]</p>
<p><i>Hospital Department Integration</i></p>	<p>N/A</p>	<p>“We’re very connected around the safety reporting system.” [38D, AMC Manager]</p> <p>“...we're not going to duplicate services by having pulmonary rehab here [at Community] and pulmonary rehab there [at AMC] or having a</p>

		<p>joint center here and a joint center there...we're going to put the joint center at Community for the AMC family or we're going to put the headache center, which it is, at Community for the AMC family so that there is not a duplicative service offering. It offers efficiency. It cuts costs both for the hospital and for providers because we are a lower cost structure of delivery.” [01S, Community Chief]</p> <p>“We're really looking at what guidelines and criteria and processes that we can share with AMC so that the patient experience is seamless, but how to really customize it to Community since we are a community hospital and we do have a different subset of patients.” [11E, Community front-line manager]</p>
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Table 5.5 Representative data for relational schema activation and affective interpretation

Themes	Representative Data – Phase 1 (Jan 2012 – Jan 2014)	Representative Data – Phase 2 (Jan 2014 – July 2014)
<i>Power Schema</i>	<p>“We always have to ask ourselves, ‘What is AMC doing?’ Not because we want to do everything they do, but because we want our patients and our providers who are going between campuses to have a seamless experience. I can’t help that AMC is bigger than us. Most of the time the way they do something is going to rule or that is where the provider is from so it’s what they are used to...I have been sitting in forums at AMC where an AMC leader would have a question about Community...[Sometimes] they give credibility to us because we know we’re competent. Unfortunately we have to prove it to them...” [02S, Family Executive]</p> <p>“Sometimes AMC introduces systems without consulting with us or [asking for] very little consultation....They add and take things off based on their own analyses and we end up paying operational expenses to AMC every year...We’re almost not part of the decision making process. [Sometimes] we’re consulted but I don’t think we can say no.” [02D, Community middle manager]</p> <p>“The AMC folks have a superiority complex and the assumption has always been from them, ‘Let me tell you, pumpkin, how this should be’...instead of saying, ‘How does this work get done?’ It’s that they are asking the question with an embedded</p>	<p>“I’d like to see us have some strong working relationships with AMC. I think there are so many similarities and ways we could more easily move patients between the sites, but unfortunately, we generally are not seen as having the same clinical expertise. I don’t believe they think there is anything to be gained by having a relationship with us.” [03D, Community middle manager]</p> <p>“Our nurses still aren’t invited to any of AMC’s educational sessions. AMC must have tons of nursing education going on that’s probably being given to a half-empty room but it’s never been opened up to us...I sometimes feel devalued because we are just Community....being treated like we had never accomplished anything [but] we do so many things very economically. It’s somehow hurtful when AMC doesn’t see our value.” [04E, Community front-line manager]</p> <p>“That’s one good thing that AMC brought all of the computer stuff because we’re all digital now and they’ve got great IT people...[but] the people at AMC thought the people at Community were like second-class citizens. The people at Community would always say, ‘Oh well, whatever the big house wants.’ [17E, Community front-line manager]</p>

	assumption that they know more than us is not a good thing..." [06D, Community middle manager]	
<i>Intimacy Schema</i>	<p>"...when [AMC] need to spread out a little bit they spread here. But the minute capacity became available at the Mothership, people got sucked back in. So it was this back and forth, back and forth, and some programs came out here and thrived, but I think that was our purpose for a long time, was the decant valve." [02S, Family executive]</p> <p>"There's been a new infusion of leadership over there [at Community] and new people coming through, so it's not as bad as it used to be...Many of the people that they're hiring over there are coming from AMC." [34D, AMC middle manager]</p> <p>"Community understands that they're the little cousin. That's kind of a double-edged sword. In some ways, they don't mind being the little cousin because they don't have the big ship problems that we have...but on the other side, they don't get as much support or capital funding." [34D, AMC middle manager]</p>	<p>"This surgical census boomed with the AMC surgeons coming over—a lot of new faces...we won't know they're coming and we'll look at the O.R. schedule and go, 'Who's that?'...I wouldn't say people aren't as friendly because they are but there are a lot of new faces...you go to the cafeteria and you go, 'I don't know any of those people.'" [02E, Community front-line manager]</p> <p>"I work in a community hospital but we are affiliated with a world-class institution. Why not take advantage of what's at this world-class institution?" [03E, Community front-line manager]</p> <p>"So we're kind of all doing everything the same way which is the goal, but they also come over here and see how well we're run. Whereas, so I think it's brought down some of the walls and they thought like we were second class citizens. So they have more respect for us." [17E, community front-line manager]</p> <p>"There was a lot of credibility given to us knowing that we were affiliated with AMC. That's for sure. I think it brought the hospital up a lot." [16E, community front-line manager]</p>

Table 5.6 Representative data for multiple identity management

Themes	Representative Data – Phase 1 (Jan 2012 – June 2013)	Representative Data – Phase 2 (June 2013 – July 2014)
<i>Inclusionary Strategy</i>	<p>“Community is a site to me where I can deploy surgeons, and set up surgical programs, similar to our ambulatory center [in the suburbs]...” —Also, in response to follow-up questioning, he indicated that he’s “interested” in what others internal or external think about Community, that “it would” feel like a personal compliment if someone praised one of the programs he helped support at Community, that Community’s successes are his successes. [05S, AMC Executive]</p> <p>“I have been with the AMC Family for five years...now [in a role] for the Family, so I identify with both the community and city hospitals.” [08S, Family Executive]</p> <p>“We became AMC’s Community Hospital. We are an extension of them.” [10S, Community Executive]</p> <p>“I am the integration to a certain degree.” [10E, Community front-line manager]</p> <p>“If someone were to criticize Community, I wouldn’t fee as strongly as if they said something about AMC, but certainly [I would feel strongly], it’s part of the family, it’s like a cousin.” [04S, AMC Senior Manager}</p>	<p>I would say institutionally I know a lot of people [in my counterpart department] at AMC and I spend enough time there to feel like I’m part of them. I know people say you come to Community to be groomed to go to AMC but I don’t know that I would want to work at AMC. I feel like it’s less personal and I feel like there’s real value placed in actual people here.” [07D, Community Middle Manager]</p> <p>“I work in a community hospital but we are affiliated with a world-class institution. Why not take advantage of what’s at this world-class institution? That’s how I look at it.” [03E, Community Front-Line Manager]</p> <p>“I’m still using the ‘ours’ and ‘theirs’ but I’m ‘both’ now...[but] I bleed AMC blue. Yes, I am AMC. You don’t get to this position or you don’t get to work at a place like this without really breathing and drinking AMC. You wouldn’t last long if you didn’t..[but] Community is an extension of AMC. [34D, AMC Middle Manager]</p>

<p><i>Exclusionary Strategy</i></p>	<p>“I’ve always felt a strong connection to Community from the beginning to now...I’m not in the AMCPO and have remained out of the AMCPO and basically in private practice ever since being here. I still have been hanging onto my autonomy” [21S, Community chief]</p> <p>“The senior administration is now more and more coming from AMC [but] the difficulty I feel is with administration. Sometimes I don’t like the attitude. They’re from a big place....we’re more primary and secondary care. They’re tertiary. They want us to do the orthopedics and primary care and a lot of surgery and then they’ll have the big difficulty cases. We’re not all one.” [26D, Community middle manager]</p>	<p>“I think a lot of people put their heads under the basket thinking we’re part of AMC but we’re still Community. “ [04E, Community front-line manager]</p> <p>“[In 1998], we kept our identity. AMC maintained their identity. I think to a large degree that's still in place today, but it's getting tighter and tighter and tighter to the point where I think at some point, are we part of AMC or are we not....I think we’re taking more and more direction, and AMC has more and more say as to what we, as an institution, do in terms of our strategy.” [39D, Community middle manager]</p>
<p><i>Filtering Strategy</i></p>	<p>“We have an affiliation with AMC...but I’m very dedicated to Community. I’ve been here so long. It’s a huge part of who I am....it is always good to hear that patients would rather be here than at the big house” [13E, Community front-line manager]</p> <p>“Sometimes I feel like I’m part of the Family and sometimes I feel like the ugly stepchild that’s tolerated by AMC.” [04E, Community front-line manager]</p> <p>“Before the integration wasn’t as solid until they changed our name. We are an AMC facility really...I’d just like to see a little bit more of the opportunities. I don’t think [the relationship] is taken as literally on that other side...I don’t see us as competitors. I see us as having a different part</p>	<p>“I feel much less connected and devoted to the institution these days now that we are AMC’s Community Hospital. There was a time where I felt completely committed to making Community work and I would just do anything....there was a certain event with AMC where I felt very attacked and very undermined. And I felt like although I had Community support, there was just not safety in my role here....but my clinical care drives me and keeps me engaged and involved with the patients’ lives even though the business aspect of it doesn’t” [16E, Community Supervisor]</p> <p>“AMC is totally taking us over...we were totally swallowed up by a larger entity...and they are trying to make Community a mini-AMC...and I</p>

	<p>of the market...there are plenty of patients to treat....the AMC people always seem to be involved a lot earlier than we are.” [03D, Community Manager]</p>	<p>have to work with what they want to do and sometimes there isn’t a choice [but] I eat and breathe this hospital...I’m extremely loyal to this hospital and I would do anything for [it].” [06E, Community front-line manager]</p>
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Table 5.7 Representative data for strategizing activities: patterns of relating

Themes	Representative Data – Phase 1 (Jan 2012 – June 2013)	Representative Data – Phase 2 (June 2013 – July 2014)
<i>Bridging</i>	<p>“When I first got here, I had been arguing that we should just integrate Community into our – into AMC. You know it should be a campus of AMC. And we are slow, you know, with the sort of merger of the boards, the branding campaign, and some of the programmatic work we’re doing, clinical planning we’re doing. I think that vision is starting to evolve....The board members who are part of the combined board are starting to tell the same story. The branding campaign, I think, has been very effective.” [05S, AMC Executive]</p> <p>“My role spans both entities...I split my time between both entities. [08S, Family Executive]</p> <p>“I had an associate chief nurse at AMC give input on a hire...and likewise I got invited to interview someone for a Family position.” [10S, Community Executive]</p> <p>“We’re working on finding a good way to integrate the information about the programs we have here versus the programs we have at AMC and how a lot of times it’s the same service but it’s right in our community....It’s an integration like kind of figuring of what the messaging is with the two institutions...So it’s really about educating the consumers on this is AMC Healthcare. These are AMC physicians....It’s been a little bit of a</p>	<p>“I’ve seen more of an effort from the AMC leadership group to include and promote Community more...There was a webcast for all the AMC employees. The same webcast was available to the Community people but I think what was different was the speaker. They made it a point whenever there was a time for questions to ask, ‘What do you guys think of this? Do you have any questions?’” [19D, AMC middle manager]</p> <p>“My colleague at Community and I actively have tried to make sure that we have as much consistency in our policies, for instance, or that we’re doing things similarly. Fortunately, [she] and I think very much alike and we have similar backgrounds.” [40D, AMC middle manager]</p> <p>“It’s a great working relationship. I mean whatever I can’t do here, I call [my counterpart] at AMC and just say, ‘Is there any way you can help me out with this in one way or another?’ It is really a group that works collaboratively.” [03E, Community front-line manager]</p> <p>“The collaboration with AMC has been great...I feel like it’s people helping people...and I think that AMC has a lot to do with that, calling up</p>

	<p>balancing act to keep it from becoming too AMC-fied almost....I still need to appease the Community patient but that patient is probably going to come here either way...and the chiefs that have been here forever. But it's really about targeting the consumer who doesn't come here. And they want to hear about and see AMC care." [07D, Community middle manager]</p>	<p>and saying we have something, a new project in the agenda. Any interest here? And we talk about it." [03E, Community front-line manager]</p> <p>"It's more a sharing of resources...I am sending employees to AMC for help." [03E, Community front-line manager].</p>
<i>Defending</i>	<p>"In my private practice, I can see as many patients as I want and I can see them where I want and can see the type of patients I want....[The department at AMC] doesn't really dictate anything that I do over here....[21S, Community Executive]</p> <p>"I get angry and feel like saying [to AMC], 'we're just as good as you, you know' when they have that [superior] attitude. I just share that with my colleagues instead." [26D, Community middle manager]</p>	<p>"I don't think that the residents should be sent over here to practice a little AMC medicine. They should be sent over here to practice in the community environment....I'm a patient here...I want the Bozo I know, not the one that I don't know that I think is great but really isn't." [04E, Community front-line manager]</p> <p>"Nobody asked me. This [integration] is being forced upon us. A lot of the good decisions are being made behind closed doors...[so] I think conversation is guarded [at Community]. I think people think twice about what they are comfortable in saying..." [39D, Community middle manager]</p>
<i>Complying</i>	<p>"I sent a whole bunch of information over to AMC about how our...program was designed. [They said], 'Thank you, thank you thank you' and in turn I needed some information back so I could understand what they wanted to do and I never got it." [02D, Community middle manager]</p> <p>"I started having more of a relationship with AMC people...It's really more touching base with them.</p>	<p>"Here at Community the people are so much friendlier because you come walking around and people will say hello to you...I mean you go to AMC and you can walk for miles and never see a soul that you even recognize or nobody talks probably in the elevator. I mean I was over at AMC this morning. I spent three hours over there and nobody even acknowledged that I was walking by. So here at Community it's more</p>

	<p>Our functions are completely separate....I do this conference call every week because the meetings are held at AMC and I will not waste my time. I don't have time to schlep down there all the time.” [21D, Community Manager]</p> <p>“In my department, I think the changes have actually enhanced our job, but it froze us too. We're short-staffed. But we still make it work.” [05E, Community front-line supervisor]</p>	<p>like a family...but I'm partnering up with my counterpart at AMC and we have a good relationship and I think it's because so many of us like the new chief [of our department] He just came from AMC.” [17E, Community Supervisor]</p> <p>“I suggested that we have a meeting with all of us and [the other person] was like, ‘Oh well, let me discuss that with my Vice President’ and I'm like, ‘You don't need to.’..[and] I'm very aware that my role could change dramatically at any drop of a day....I'm fearful of rocking that boat...I worry that I'm going to make a misstep so the communication isn't very good.” [03D, Community Manager]</p>
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Table 6.1 Summary of the Dissertation

"How do organizations rebound from failure during post-merger integration?"		
	Chapter 4: Multiple identity resourcing at the organizational-level during post-merger integration	Chapter 5: Sensemaking about the merger relationship during post-merger integration
SUB- QUESTIONS	"How do managers from two organizations that have struggled to integrate manage the tension between identity-based 'unity' and 'distinctiveness'? How does managing this tension affect post-merger integration performance?"	"How do managers' interpretations of the merger relationship influence how they perform a post-merger integration strategy?"
UNITS OF ANALYSIS	Praxis (e.g., organizational identity work); Practices (e.g., discourse, name changes)	Practitioners (e.g., meaning construction); Practices (e.g., strategic change)
CROSS-LEVEL RELATIONSHIPS EXAMINED	Individual-level to group-level to organizational-level	Organizational-level to individual-level; individual-level to organizational-level
KEY MECHANISMS	Organizational identity negotiation	Relational dynamics (i.e., power, intimacy, patterns of relating)
MAJOR FINDINGS	Collective engagement in multiple identity resourcing can transform the unhealthy tension between “become one” (i.e., creating unity) and “remaining separate” (i.e., maintaining distinctiveness) in a merger relationship into one that is much more functional and useful for creating collective value (i.e., sharing and generating resources).	When confronted with strategic change during post-merger integration (i.e., a new integration strategy), managers at all levels and across organizations engage in a meaning construction process in which they interpret relational schema that are activated in light of the change, manage their own conceptualizations of the multiple organizational identities in the relationship, and engage in relationally-oriented strategizing activities. This meaning construction process drives further strategic change (i.e., strategy modification) that results in successful strategy implementation.

	Chapter 4: Multiple identity resourcing at the organizational-level during post-merger integration	Chapter 5: Sensemaking about the merger relationship during post-merger integration
KEY CONTRIBUTIONS	<p>Changing the level of dialogue to one of identity rather than resources actually fosters resource sharing and generation in the context of post-merger integration (via multiple identity resourcing). Complements and extends prior research at the individual-level that links identity dynamics to resource dynamics in organizations (Caza & Wilson, 2009; Creary, 2015; Creary, Caza, & Roberts, forthcoming; Dutton, Roberts, & Bednar, 2010; Ely & Thomas, 2001).</p>	<p>Meaning construction during strategic change has both cognitive and affective dimensions and understanding both is important to understanding the different ways in which organizational members respond to strategic change. Further, affective responses are not simply positively or negatively valenced; they also reflect ambivalence. This finding contrasts with past research on meaning construction during strategic change which primarily characterizes meaning-making by its cognitive components and differences in cognitive responses by managerial level (Balogun et al., forthcoming; Balogun & Johnson, 2004) or organizational membership (van Knippenberg et al., 2002)</p>
	<p>Complements and extends prior research on multiple identity management at the organizational level that reveals different managerial responses to managing the dynamics of plurality and synergy in light of multiple organizational identities (Pratt & Foreman, 2000). Specifically, I reveal an “inclusion” strategy that establishes optimal distinctiveness in the context by creating two levels of overlap in organizational identity at the organizational-level while establishing a larger superordinate, common and more “visible” identity with which members of both organizations could identify (cf., Brewer, 1991).</p>	<p>The broader relational context plays a substantial role in how managers respond to strategic change, make sense of a merger relationship, and perform an integration strategy. Those who felt more positive about the relational dynamics in merger relationship were more likely to make, shape, and execute the new strategy. Those who felt more negative about the relational dynamics were less supportive of the new strategy, though not "resistant." This finding stands in contrast to past research on strategic change which suggests that individuals with negative meanings of change frequently “resist” change (Sonenshein, 2010). Of note, managers with both negative and positive meanings of change (i.e., ambivalence) actually complied with the integration process.</p>

FIGURES

Figure 4.1: Data Structure for Chapter 4

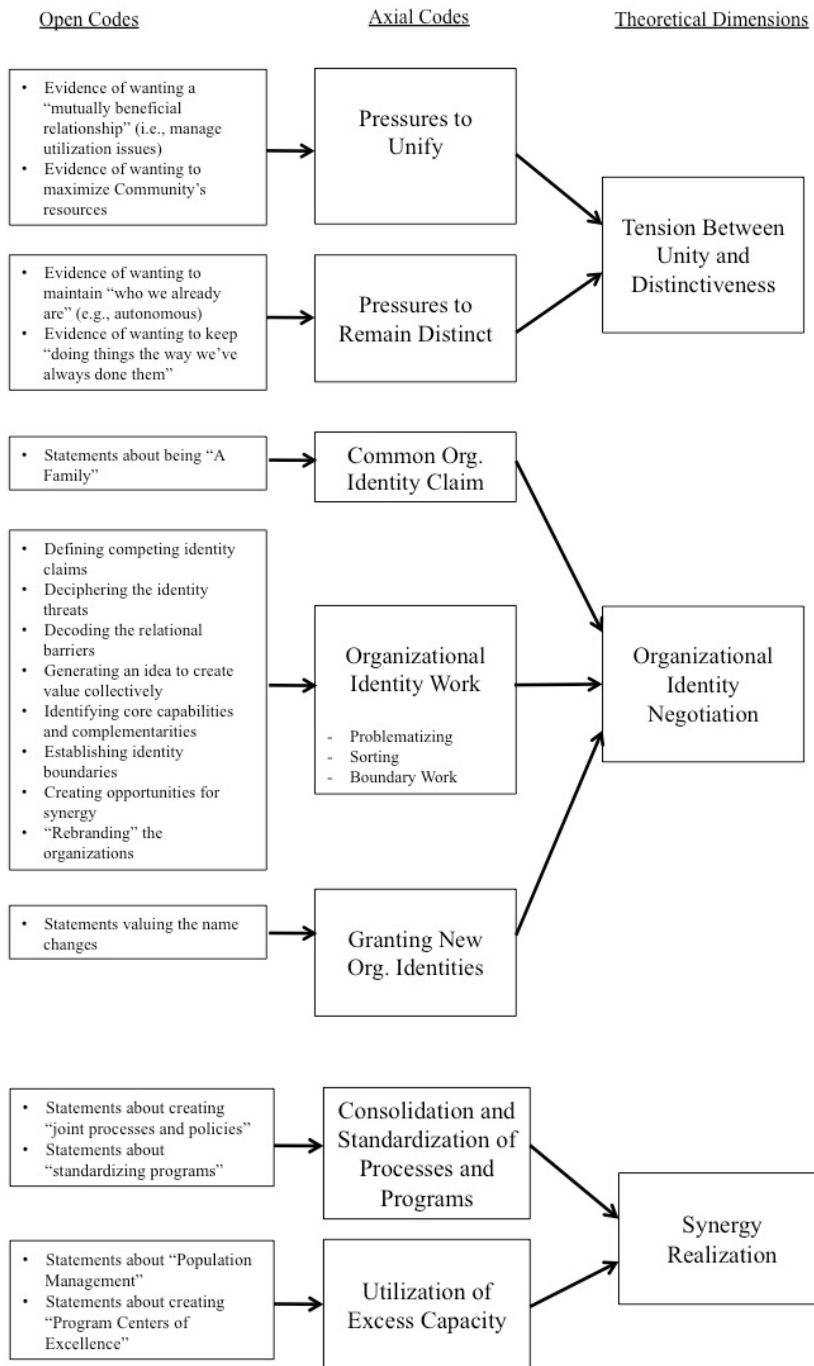


Figure 4.2: A Process Model of Multiple Identity Resourcing at the Organizational-Level During Post-Merger Integration

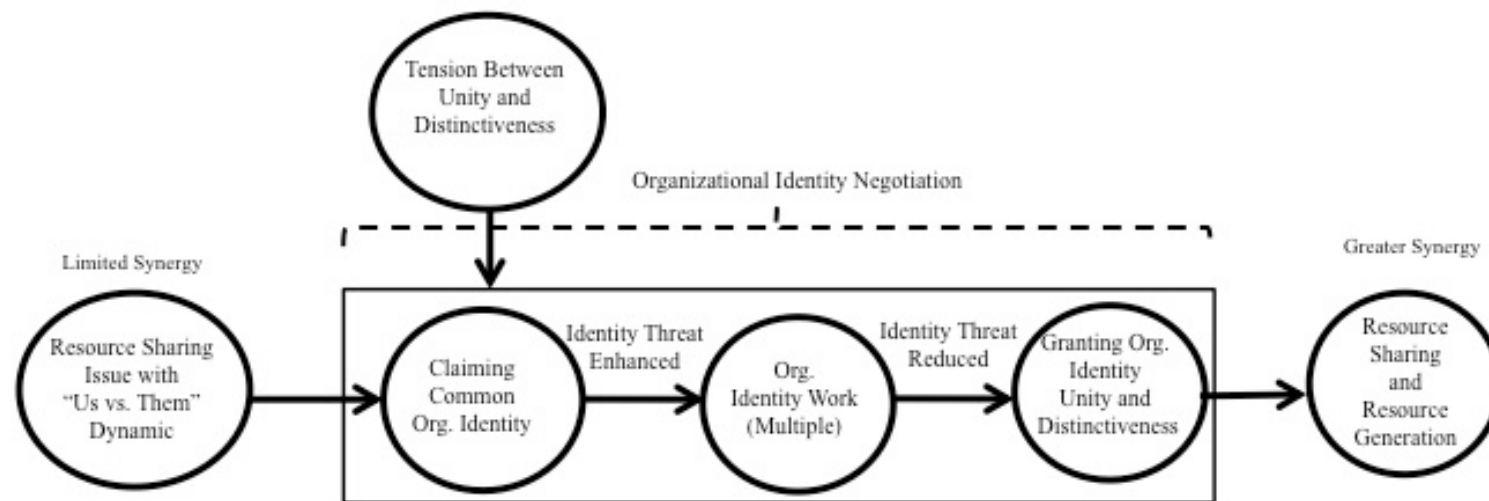


Figure 5.1: Data Structure for Chapter 5

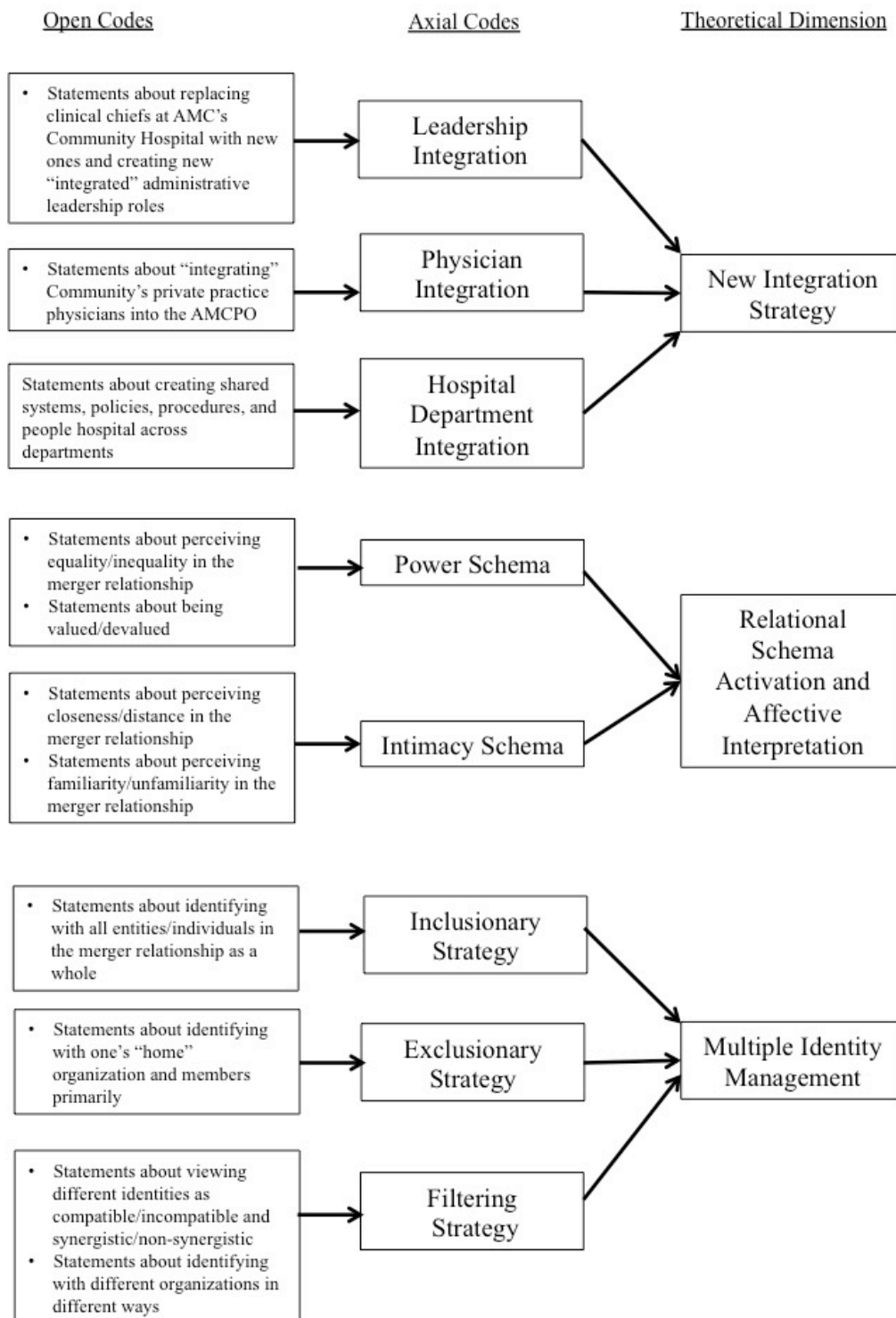


Figure 5.1: Data Structure for Chapter 5 (continued)

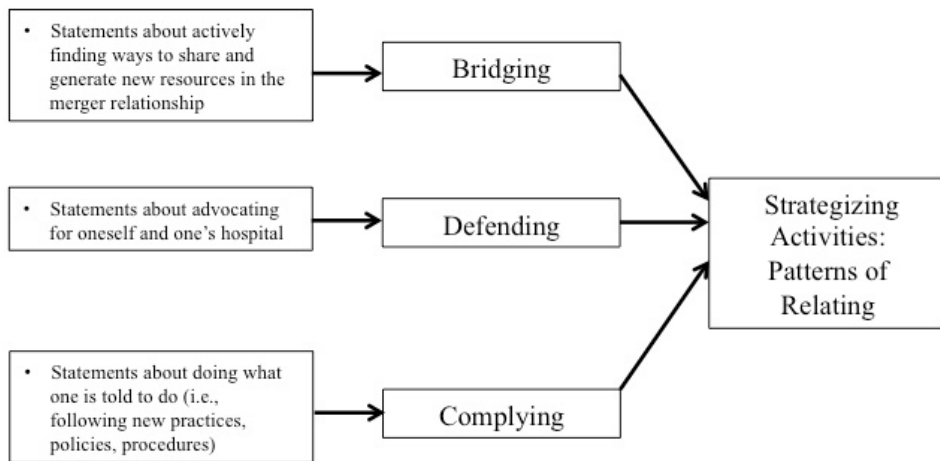
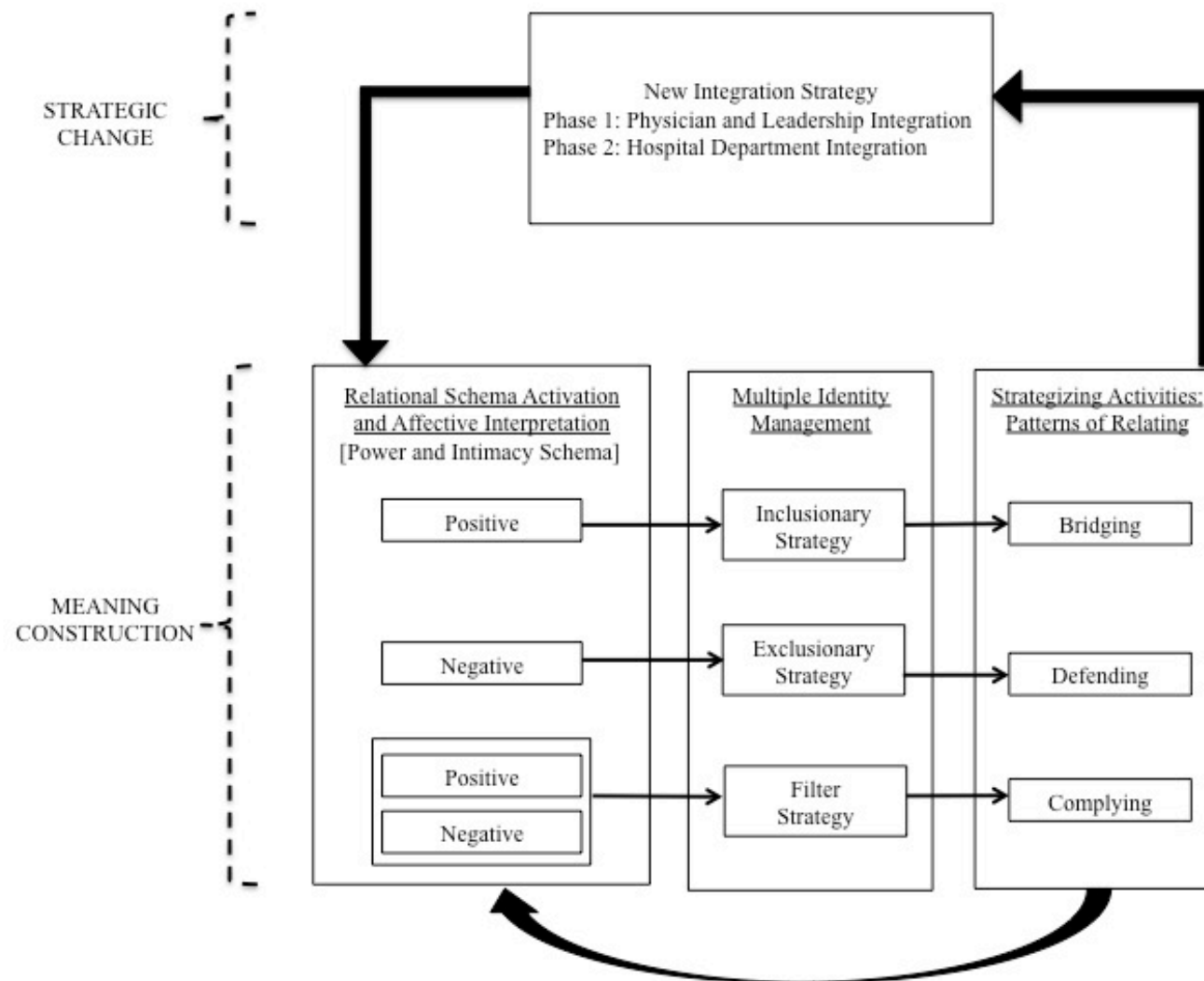


Figure 5.2: A Model of Sensemaking about the Merger Relationship During Post-Merger Integration



APPENDICIES

APPENDIX 1

Interview Protocol #1 – Community Middle Managers

Code: _____

Location: _____ Date/Time: _____

Background / General Questions

1. Tell me about yourself. What is your role at this Hospital? What do you do on an average day? Do you sit on committees? If so, which ones?
2. Why did you decide to become a (specialty)?
3. For how long have you been the head of X department? Why did you decide to become a department head? What were the circumstances surrounding your assumption of this role?
4. What skills, knowledge, relationships, tools are required to do your job? How have you acquired them?

Questions about Specific Experiences as a Department Head and the Integration

5. How would you describe your experience so far as a department head? What is going well? What has been challenging for you so far?
6. What has been your role in the integration process? What is going well? What has been challenging for you so far?
7. What role, if any, does having both a clinical and managerial background play in this Hospital in general? In the integration process?
8. How do department heads influence key goals and outcomes at this Hospital such as patient care and delivery, patient safety, cost reduction, and hospital utilization efficiency?
9. With whom do you interact most frequently with respect to your role? How would you describe these interactions? Support? Challenges?
10. Tell me about your department/your staff. What is going well? What has been challenging?
11. What are the barriers/challenges, if any, affecting department heads at this Hospital?
12. Is there anything else about your experiences so far as a department head that you want to share with me?

APPENDIX 2

Interview Protocol #1 – Senior Managers (AMC and Community)

Code: _____

Location: _____ Date/Time: _____

General questions about your work

1. Tell me about yourself. What is your role at this Hospital? For how long have you been in the role? What do you do on an average day? For how long have you been at the Hospital?
2. Why did you decide to become a (specialty)? How have you acquired the skills, knowledge, and relationships to do your job?
3. What do you like most about your job? What do you like least about your job?
4. What role, if any, does having both a clinical and managerial background play in this Hospital in general?

Questions about your relationship to the hospital

5. Would you say that you are interested in what others think about The Hospital? If someone criticized The Hospital, would it feel like a personal insult? If someone praised the hospital would it feel like a personal compliment? Do you feel like the Hospital's successes are your successes?

Questions about the integration

1. Can you tell me a bit about the integration process? In what phase is the Hospital currently? What have been the barriers/challenges? The opportunities? The successes? What have been the necessary tools?
2. What is your role in the integration process?
3. What role, if any, does having both a clinical and managerial background play in this Hospital in general? In the integration process?

Specific Questions about Clinical Department Heads

4. What is the nature of your interactions with clinical department heads?
 - a. How frequently do you interact with clinical department heads?
 - b. Under what conditions?
 - c. Describe the typical interactions that you have.
5. Describe several qualities of “the ideal clinical department head” from the perspective of the Hospital. What qualities does this person have? How do they behave?
6. What types of support does the Hospital offer to clinical department heads? You personally?
7. What are the barriers/challenges affecting clinical department heads? What role, if any, do you play in facilitating their development?

8. What general advice would you offer to clinical department heads? Specific advice related to the integration process?
9. Anything else you would like to add?

APPENDIX 3

Observation Protocol #1 – Work Setting

Participate Codes: _____

Location: _____ Date/Time: _____

1. Setting/Context: Where is/are the interaction(s) taking place?
2. Goals: Why are individuals interacting? What is the purpose of the interaction(s)
3. People Interacting: Who is interacting?
4. Time: When is/are the interaction(s) taking place?
5. Process: What are the people doing? What are they talking about? What process are they using/actions are they taking?

APPENDIX 4

Interview Protocol #2 – Community Middle Managers

Code: _____

Location: _____ Date/Time: _____

Background / Questions about Work, Identity, and Subjective Experiences

1. Tell me about yourself. What is your role at this Hospital? How has what you do changed, if at all, since the hospital restructuring in 2010?
2. What does it mean to you to be the X(role) at Community?
3. How do you introduce and describe yourself to other people at work? How much does being a (*fill in with their answer*) describe you as a person?
4. Why did you decide to become a (specialty)? How much/ to what degree does being a (specialty) define you as a person?
5. For how long have you been the head of X department? Why did you decide to become a department head? What were the circumstances surrounding your assumption of this role?
6. What do you do on an average day? With whom do you interact most frequently with respect to your role? Has this changed since 2010? If so, in what way?
7. Tell me about your department/your staff. What is going well? What has been challenging?
8. Do you sit on committees? If so, which ones? Who do you work with on these committees? What do you do? Again, in what way, if any, has this changed since 2010?
9. What skills, knowledge, tools, etc. are required to do the work that you do? How have you acquired them? Are there any skills, knowledge, tools, and the like that you think you need but do not have? If so, how might you get them?
10. How would you describe your experience so far as a department head? What is going well? What has been challenging for you so far? How, if at all, has this changed since 2010?
11. In your opinion, describe the ideal department head. Has this definition changed since 2010?
12. Does the Hospital utilize you well? Are there any aspects that the hospital utilizes particularly well? Any aspects of you that they do not?
13. *For those who also have a clinical background:* What role, if any, does having both a clinical and managerial background play in the work that you do? How if at all has this changed since 2010?
14. *For those who previously worked at AMC Hospital:* What role, if any, does your affiliation with AMC Hospital play in the work that you do?

Questions related to Goals and Identity Enactment (Link back to their answers to identity questions)

15. What are 3-5 of your department's goals for this year? How, if at all, are those related to the Hospital's goals?
16. Are any of your goals related to the integration with AMC Hospital? In what way(s)?

17. What was your process for establishing these goals this year? How does that differ from the process you've used in previous years? Prior to 2010?
18. What is/has been your plan for executing your goals this year?
19. Given the goals you have discussed, in what ways do these goals and their execution play into your strengths? In what ways might they not?
20. What type of support will/have you need to attain these goals? [probe for areas where they feel goals align with who they are and where they do not]
21. What is the process that you will use/have you used to get the support that you need to meet these goals?
22. What are/have been the barriers/challenges, if any, affecting your ability to meet these goals?
23. Where do you currently stand with respect to meeting your goals? How have you managed to meet them?
24. Is there anything else about your experiences so far as a department head that you want to share with me?

APPENDIX 5

Follow-Up Interview Protocol – Community Middle Managers

Code: _____

Location: _____ Date/Time: _____

Questions about Goals and Identity Enactment (Link back to answers to initial interview questions about their identity)

1. How have things been going at work since we last spoke?
2. What does it mean to you to be the X(role) at Community?
3. What are 3-5 of your department's goals for this year? How, if at all, are those related to the Hospital's goals?
4. Are any of your goals related to the integration with AMC Hospital? In what way(s)?
(goals)
5. What was your process for establishing these goals this year? How does that differ from the process you've used in previous years? Prior to 2010?
6. What has been your plan for executing your goals this year?
7. Given the goals you have discussed, in what ways do these goals and their execution play into your strengths? In what ways might they not?
8. What type of support will you need/have you needed to attain these goals? [probe for areas where they feel goals align with who they are and where they do not]
9. What is the process that you will use/have you used to get the support that you need to meet these goals?
10. What are/have been the barriers/challenges, if any, affecting your ability to meet these goals?
11. Where do you currently stand with respect to meeting your goals? How have you managed to meet them?
12. Does/has the Hospital utilize/d you well? Are there any aspects that the hospital utilizes particularly well? Any aspects of you that they do not?
13. Is there anything else about your experiences so far as a department head that you want to share with me?

APPENDIX 6

Follow-Up Interview Protocol – AMC Senior Managers

Code: _____

Location: _____ Date/Time: _____

Questions about Multiple Identities and Identity Enactment

1. How have things been going at work since we last spoke?
2. How do you introduce and describe yourself to other people at work? How much/ to what degree does being a (*fill in with their answer*) define you as a person?
3. What does it mean to you to be the X(role) at AMC?
4. How would you describe your experience this year as a senior leader? What is going well? What has been challenging for you so far?
5. Tell me about your department/your staff. What is going well? What has been challenging?
6. Do you sit on committees? If so, which ones? Who do you work with on these committees? What do you do? Again, in what way, if any, has this changed since 2010?
7. Do you work with other senior leaders or department heads at Community Hospital? If so, in what ways? If not, why? How, if at all, has this changed since 2010?
8. Do you oversee any projects that require you to work with people at Community Hospital?
9. What skills, knowledge, tools, etc. are required to do the work that you do? How have you acquired them? Are there any skills, knowledge, tools, and the like that you think you need but do not have? If so, how might you get them?
10. Given the goals you have discussed, in what ways do these goals and their execution play into your strengths? In what ways might they not?
11. Does the Hospital utilize you well? Are there any aspects that the hospital utilizes particularly well? Any aspects of you that they do not?
12. *For those who also have a clinical background:* What role, if any, does having both a clinical and managerial background play in the work that you do?
13. Is there anything else about your experiences at work this year that you would like to share with me?

Questions about Goals and Resources (Link back to their answers to identity questions)

14. Are you familiar with any goals that AMC Hospital has that are related to the integration with Community Hospital? Did you play a role in setting these goals? Will you play a role in the execution of these goals? If so, how? How, if at all has this changed since 2010?
15. Has the relationship between Community and AMC changed from your perspective since we last spoke? If so, how?
16. What do you think needs to be done in order to further the integration process?

APPENDIX 7

Follow-Up Interview Protocol #2 – Community Senior Managers

Code: _____

Location: _____ Date/Time: _____

Questions about Multiple Identities, Goals, and Identity Enactment

1. How have things been going at work since we last chatted? What has been going well? What has been challenging?
2. How do you introduce and describe yourself to other people at work? How much/ to what degree does being a (specialty) define you as a person?
3. How would you describe your experience this year as a senior leader? What is going well? What has been challenging for you so far?
4. Tell me about your department/your staff. What is going well? What has been challenging?
5. Do you sit on committees? If so, which ones? Who do you work with on these committees? What do you do? Again, in what way, if any, has this changed since 2010?
6. Do you work with other senior leaders or department heads at AMC Hospital? If so, in what ways? If not, why? How, if at all, has this changed since 2010?
7. What skills, knowledge, tools, etc. are required to do the work that you do? How have you acquired them? Are there any skills, knowledge, tools, and the like that you think you need but do not have? If so, how might you get them?
8. Does the Hospital utilize you well? Are there any aspects that the hospital utilizes particularly well? Any aspects of you that they do not?
9. *For those who also have a clinical background:* What role, if any, does having both a clinical and managerial background play in the work that you do?
10. *For senior leaders who previously worked at AMC Hospital:* What role, if any, does your affiliation with AMC Hospital play in the work that you do?
11. Is there anything else about your experiences at work this year that you would like to share with me?

Questions about Goals and Identity Enactment (Link back to their answers to identity questions from pilot study)

12. Tell me about the process the senior leadership team used to set the annual goals that were presented during the Leadership Retreat in October 2013? What role did you play in this process? What was the process in previous years?
13. Did you work with department heads (i.e., your direct reports) to establish their departmental goals? What was the process that you used this year? How does that compare to the process you used in previous years?
14. How, if at all, are their departmental goals related to the integration with AMC Hospital?

15. What type of support is needed in order for the hospital to meet its goals? For the department heads to meet their goals? [probe for areas where they feel goals align with who they are and where they do not]
16. Given the goals you have discussed, in what ways do these goals and their execution play into your strengths? In what ways might they not?
17. What are the barriers/challenges, if any, affecting the Hospital's ability to meet its goals? Affecting department heads' abilities to meet their goals?

APPENDIX 8

Observation Protocol #2 – Work Setting

Participate Codes: _____

Location: _____ Date/Time: _____

Mechanisms for identity enactment, identity as a resource

1. Setting/Context/Space: Where is/are the interaction(s) taking place? Describe the space. (e.g., layout, artifacts, location)
2. Goals: Why are individuals interacting? What is the purpose of the interaction(s)
3. People Interacting: Who is interacting?
4. Time: When is/are the interaction(s) taking place?
5. Process: What are the people doing? What are they talking about? What process are they using/actions are they taking?
6. Enactment: What skills/knowledge/relationships are being deployed in this setting? How are they being deployed in this setting?

APPENDIX 9

Physician Manager Interview Protocol

Participant: _____ Code: _____
Location: _____ Date/Time: _____

General questions about your work

1. Tell me about yourself. What is your role at this Hospital? For how long have you been in the role? What do you do on an average day? For how long have you been at the Hospital?
2. Why did you decide to become a (specialty)? How have you acquired the skills, knowledge, and relationships to do your job? How much does being a [specialty] describe you as a person?
3. Do you work with other senior leaders or department heads at Community Hospital? If so, in what ways? If not, why? How, if at all, has this changed since 2010?

Questions about the integration

1. Can you tell me a bit about the integration process? What is/has been your role?
2. What have been the barriers/challenges? The successes?
3. How, if at all, has the relationship between AMC and Community changed?
4. What do you think needs to be done in order to further the integration process?

APPENDIX 10
Interview Protocol – Front Line Managers and AMC Middle Managers

Code: _____

Location: _____ Date/Time: _____

Background / Questions about Work, Identity, and Subjective Experiences

1. Tell me about yourself. What is your role at this Hospital? How do you introduce and describe yourself to other people at work? How has what you do changed, if at all, since the hospital restructuring in 2010?
2. For how long have you been in this role? Why did you decide to take this role? What were the circumstances surrounding your assumption of this role?
3. How much does being a (*fill in with their answer*) describe you as a person?
4. Why did you decide to become a (specialty)? How much/ to what degree does being a (specialty) define you as a person?
5. What do you do on an average day? With whom do you interact most frequently with respect to your role? Has this changed since 2010? If so, in what way?
6. Tell me about your department. What is going well? What has been challenging?
7. What skills, knowledge, tools, etc. are required to do the work that you do? How have you acquired them? Are there any skills, knowledge, tools, and the like that you think you need but do not have? If so, how might you get them?
8. Does the Hospital utilize you well? Are there any aspects that the hospital utilizes particularly well? Any aspects of you that they do not?
9. To what extent to you identify with Community? With AMC?
10. *For those who have a clinical and managerial background:* What role, if any, does having both a clinical and managerial background play in the work that you do? How if at all has this changed since 2010?
11. *For those who previously worked at AMC Hospital:* What role, if any, does your affiliation with AMC Hospital play in the work that you do?
12. What has been your role in the integration process? What is going well? What has been challenging for you so far?

13. Is there anything else about your experiences as a Community employee or with the integration that you want to share with me?

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