THE CONCEPT OF MICRO-MERGING WITHIN PROFESSIONAL SERVICES

A CASE STUDY IN THE DUTCH HEALTHCARE INDUSTRY

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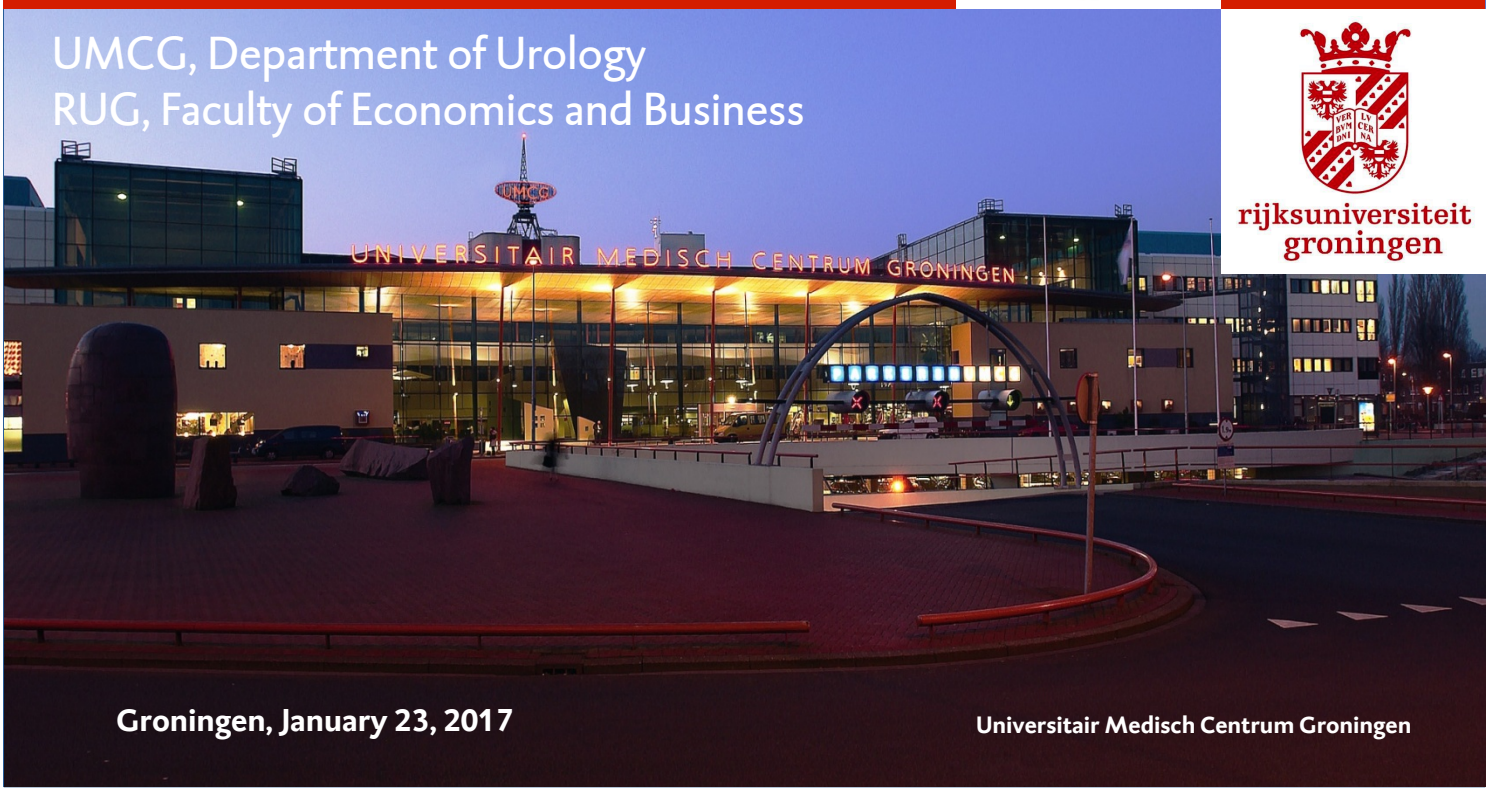

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The Concept of Micro-Merging within Professional Services: A Case Study in the Dutch Healthcare Industry

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ABSTRACT

Although the literature on mergers and acquisitions (M&As) is quite advanced, analyses of micro-mergers—mergers of internal functional units within the same organization—remain limited. Clarification is needed regarding micro-mergers and their effects on performance. Therefore, this case study investigated micro-mergers within professional service firms (PSFs), specifically focusing on healthcare providers. Thereby, this study addresses the following research question: How do different types of micro-mergers affect the performance of PSFs? Thus, it examined the various types of micro-mergers and the relationship between the type of micro-merger and PSF performance. In addition, it focused on the factors moderating the relationship between the type of micro-merger and PSF performance. This study analyzed data on three cases within University Medical Center Groningen (UMCG). Twenty-one semi-structured interviews provided the bulk of this data. The results demonstrated that Napier's (1989) typology of mergers also applies to micro-mergers, since all three types of micro-mergers (extension, collaborative, and redesign) were identifiable. None of these micro-merger types led to a decline in the PSF's performance. The collaborative and redesign micro-mergers led to an increase in the PSF's performance. Furthermore, the results indicated that merging syndrome moderates the relationship between the type of micro-merger and PSF performance. Moreover, two factors affect the severity of the merging syndrome: equivalency and feelings of unity (social identity). Regarding future research, researchers should explore whether these results hold true for other micro-mergers. Furthermore, the conceptual framework proposed should be further explored in a quantitative matter by measuring PSF performance. Regarding managerial implications, management should be aware that governance has significant effect on the micro-merging process. Thereby, communication is key to reduce uncertainty and stress, so as to create high levels of trust.

Keywords: micro-merging, professional service firms, merging syndrome, social identity
Word count: 14905

INTRODUCTION

The literature on the relationship between competition and innovation dates back more than 100 years (Haucap & Stiebale, 2016). One popular topic pertains to corporate combinations, which refers to the merging of separate entities into a new firm, or the acquisition of one firm by another, to gain flexibility, leverage competencies, share resources, or create opportunities that would otherwise be unreachable (Marks & Mirvis, 2001). The recent literature on mergers and acquisitions (M&As) mostly focuses on domestic or cross-border M&As (e.g., Caiazza & Volpe, 2015; Sinkovics, Zagelmeyer & Kusstatscher, 2011). Domestic M&As include the merger or acquisition of firms operating in the same home country, whereas cross-border M&As are transactions involving firms located in different countries (UNCTAD, 2000). However, mergers can also occur at the micro level. For example, internal functional units belonging to the same organization that previously operated as separate entities might merge with one another (Lawlor, 2013). This type of merger is called a micro-merger (Kilfoil & Groenewald, 2005). However, only a limited amount of literature exists on the topic of micro-mergers. Therefore, this paper seeks to contribute to the literature on micro-mergers by exploring that process within professional service firms (PSFs). In particular, it focuses on the healthcare industry.

PSFs are specialized providers of knowledge-intensive, high-skilled services delivered by a well-educated, professional workforce (Bello, Radulovich, Javalgi, Scherer, & Taylor, 2016; Reihlen & Apel, 2007). In this paper, healthcare fills the role of a professional service, while hospitals constitute PSFs. According to Kraaij, Heinen, and de Blok (2012), the healthcare industry is facing a redistribution and concentration of healthcare, and hospitals are being forced to rethink their position in the market. Clustering healthcare services to achieve specialization is one way that hospitals can respond to the industry's changing environment (Kraaij, et al., 2012). Therefore, healthcare systems in many countries are moving towards a patient-centered approach to provide high-quality care (Damman, Hendriks, & Sixma, 2009). To that end, the healthcare industry is creating comprehensive centers, most of which are located in university-affiliated hospitals. By situating multiple healthcare providers in close geographic proximity to each other, these centers simplify patient access (Auchus, et al., 2010). Different specialists must collaborate as a team, meaning that a diverse range of disciplines must form clusters to provide the best patient care.

Although some previous studies have focused on why healthcare providers merge (Appelbaum & Gandell, 2003; Postma & Roos, 2016), literature offering insights into the process of healthcare mergers is lacking. In addition, the existing literature on healthcare mergers has only concentrated on mergers between healthcare insurers, pharmaceutical companies, or other organizations belonging to the healthcare industry (Postma & Roos, 2016). No studies have focused on mergers of healthcare providers, such as hospitals.

Additionally, the empirical literature on M&As has deeply examined the effect of mergers on firms, with a particular emphasis on the consequences for human resources (e.g., Postma & Roos, 2016; Daniel, 1999; Devoge & Shiraki, 2000; Ivancevich, Schweiger & Power, 1987; Lawlor, 2013; Napier, 1989). As such, the literature has focused on how employees' social identity changes following a merger,

as the new organization incorporates a change in group membership (van Knippenberg et al., 2002). However, the existing literature has not described how merging affects PSF customers. Nonetheless, writing about the healthcare industry, Hayford (2012) noted that merging has a different effect on healthcare providers and manufacturing firms regarding both price and non-price dimensions. According to her, the non-price dimension–healthcare quality–may be the most important for healthcare providers, because it is essential for both survival and quality of life. Thus, micro-merging processes might have an effect on the customers of healthcare providers in terms of healthcare quality.

Furthermore, Napier (1989) differentiated between three types of mergers: extension mergers, collaborative mergers, and redesign mergers. However, considering the different size and scope of micro-mergers, it is necessary to examine whether these types can be applied to micro-mergers.

Thus, although literature exists on mergers and their consequences, clarification is needed regarding the relationship between different types of micro-merges and their consequences. In particular, more research is needed regarding the effects on PSF performance, as measured in terms of quality. Moreover, a better understanding is needed of the factors that moderate the relationship between types of micro-mergers and their outcomes. Therefore, this paper contributes by generating insights regarding PSF micro-mergers by exploring: (1) types of micro-mergers within PSFs; (2) the outcomes of the micro-merging process within PSFs, especially regarding improvements to service quality; and (3) the factors moderating the relationship between micro-mergers and their outcomes. This objective led to the following research question: **How do different types of micro-mergers affect the performance of PSFs?**

Especially regarding PSFs, managing a micro-merging process is difficult because it takes transferring individuals' tacit knowledge as the main resources (Empson, 2001). To achieve an increased performance within PSFs due to micro-mergers, management needs to gain insights on the process of micro-mergers and the factors moderating the micro-mergers. Thus, the practical relevance of this study is to develop a better understanding of the micro-merging process within PSFs and how micro-mergers can be managed. Therefore, results of this study will provide management some insights on the governance of micro-merging.

In order to get a better understanding of the micro-mergers process, three cases of micro-mergers within University Medical Center Groningen (UMCG) were selected. Data was gathered by twenty-one semi-structured interviews. Additionally, secondary data was gathered by analyzing documents such as the internal newsletter, policy plans, and implementation plans of the three cases.

The remainder of this paper is structured as follows: The next chapter reviews the existing literature to provide theoretical background information on professional services, (micro-)mergers, merging syndrome, and the role of mergers regarding social identity. The third chapter discusses the methodology. Next, the case-study results are presented. The following chapter presents a proposed model of the micro-merging process within PSFs and reflects on the literature. The paper ends with a conclusion, which details the study's limitations and provides suggestions for further research.

LITERATURE REVIEW

In order to understand the relationship between micro-mergers and their outcomes, this study relies on five theoretical bases. These are: professional services, (micro-)mergers, merging syndrome, social identity, and the role of mergers in social identity. In this chapter, these five theoretical bases are described.

Professional services

Within the literature, there has been a growing interest in PSFs, because they are presumed to be distinct from other types of firms and to require distinctive theories of management (von Nordenflycht, 2010). Knowledge and experience are PSFs' main resources (D'Antone & Santos, 2016). Traditional professional service industries include law, accounting, management consulting, IT/software development, real estate, architecture, and engineering (e.g., Bello et al., 2016; Ross, 2016; von Nordenflycht, 2010). Despite the differences between these industries, they all specialize in the creation, validation, and application of knowledge with the goal of solving client problems. Moreover, in all of these cases, the professional delivering the service must provide a high degree of customization, interaction, discretionary effort, and personal judgment (Reihlen & Apel, 2007).

Healthcare as a professional service. Healthcare is an enormously expensive, highly complex, and universally used service that people need but do not necessarily want (Berry & Bendapudi, 2007). Von Nordenflycht (2010) claimed that healthcare is more capital-intensive than classic professional service industries, because delivering healthcare requires both an intellectually skilled workforce and significant non-human assets, such as medical equipment and a large, specialized building.

Innovation in professional service firms. Lee, Ginn, and Naylor (2009) recognized that service innovations are essential to meet the competitive challenges that emerging markets pose for firms. Therefore, successful PSFs must offer highly innovative services with unique, high-quality offerings distinct from those of their competitors (Bello, et al., 2016). In this paper, improvements to the quality of professional services are deemed a form of innovation.

Improvements to the quality of professional services. Improvements in terms of quality, customer satisfaction, and employee satisfaction are all elements of a PSF's judgmental (subjective) performance (Agarwal et al., 2003). Previous studies have defined service quality as the difference between customers' expectations and perceptions regarding the service performance and the actual performance that the customers received (Gupta & Zeithaml, 2006; Gijsenberg, van Heerde, & Verhoef, 2015). However, regarding the quality (or performance) of professional services (e.g., healthcare), customers (patients) might receive the same service (healthcare) but experience it in different ways, depending on their current condition (Vogus & McClelland, 2016). Therefore, high-quality care should be highly customized to meet the needs of individual patients (Vogus & McClelland, 2016).

Merging

The literature on merging often confuses mergers with acquisitions. Only few of the supposed mergers examined in the literature are true mergers. In contrast, most are actually acquisitions in which one company acquires another (Greenwood, Hinings & Brown, 1994). This paper defines a merger as *the consolidation of two different companies or assets, in which two parties combine their assets and operations, and share their resources to establish a new legal entity and achieve common objectives* (Marks & Mirvis, 2011; Lawlor, 2013). According to Cartwright and Cooper (1993), mergers seek to achieve the "two plus two equals five" effect, meaning that their usual objective is to enhance the firms' overall performance and competitive advantage. However, those authors also noted that merging does not guarantee that this potential will be realized.

Napier (1989) indicated that the purpose of a merger is related to its type. She differentiated among three types of mergers: extension mergers, collaborative mergers (which can be further broken down into synergy mergers and exchange mergers), and redesign mergers. In extension mergers, the acquiring organization does not intend to change their structure and operations. In collaborative mergers, the two firms join each other to generate gains through exchanging their expertise or blending their operations, assets, or cultures. Synergy mergers are a subtype of collaborative mergers in which two firms integrate their operational and managerial functions, such as staff operations and headquarters. Exchange mergers are a subtype of collaborative merger that involve an exchange of knowledge, talent, or technology between firms. A redesign merger implies one firm's adoption of another's policies and practices.

Merging professional services. According to Empson (2000), increasing value creation via a PSF merger is extremely difficult. Such mergers only create new value when resources are transferred between the combined firms (Empson, 2000). Mergers between manufacturing firms are driven by, inter alia, the desire to exploit economies of scale. However, in mergers between PSFs, technical expertise and client relationships are the resources that create value (Empson, 2000). Such technical expertise and client knowledge are often proprietary to a firm's employees. In most cases, such knowledge is tacit, belongs to individual employees, and is challenging to communicate. Likewise, client relationships are mostly based on close, personal relationships between individuals (Empson, 2001).

In the Netherlands, healthcare providers have a variety of motivations for merging. These include improving quality, strengthening one's market position by achieving a greater market share via a merger with a competitor, and enhancing one's bargaining position vis-à-vis competitors (Bazzoli, LoSasso, Arnould, & Shalowitz, 2002; Postma & Roos, 2016; Schmid & Varkevisser, 2016). In addition, pressure from third parties (e.g., the government; other external stakeholders, such as health insurers; or internal stakeholders, such as physicians and management) can influence merger decisions (Postma & Roos, 2016).

Micro-mergers. This paper focuses on micro-mergers and relies on Kilfoil and Groenewald's (2005) definition, deeming a micro-merger to refer to a merger of two separate internal functional units into a single internal functional unit. To the best of knowledge, the literature has almost completely overlooked the topic of micro-mergers. The exception is Lawlor (2013), who reported on a faculty merger in a higher education institution, focusing on that micro-merger's effect on employees.

Merger syndrome

Marks and Mirvis first documented the phenomenon of merger syndrome in 1985, and it describes how both employees and managers react to a merger (Sinkovics, et al., 2011; Marks & Mirvis, 2011). Merger syndrome is a comprehensive set of typical reactions to mergers, including: the centralization of decision-making; stress; changes to one's identity; decreased productivity; and feelings of fear, insecurity, loss of autonomy, anxiety, and mistrust (e.g., Marks & Mirvis, 2011; Sinkovics, et al., 2011; Napier, 1989; Appelbaum & Gandell, 2003; Ivancevich, et al., 1987; Appelbaum, Gandell, Yortis, Proper, & Jobin, 2000; Kilfoil & Groenewald, 2005). Sinkovics, et al. (2011) emphasized that emotions are an important component to which the literature has paid scant attention. During mergers, people can experience negative emotions, prompting them to either resist the change or withdraw. Therefore, managers must be aware of their own emotions, and they also must learn to cope with those of their co-workers. Collaborative mergers can lead to major changes, including transfers, the creation of new teams, replacements of teams, or even staff reductions when certain units are combined (Napier, 1989). The increased uncertainty can trigger emotions, as rumors spread about restructuring and eventual job losses, causing employees to perceive a threat to their social identity (Sinkovics, et al., 2011).

Social identity

When organizations merge, they combine not only their buildings, plants, and equipment but also their individual structures, people, policies, and cultures (Appelbaum et al., 2000). The literature on how intergroup merger (and acquisition) dynamics influence organizational identity and identification explores the topic from a social identity perspective. Individuals define themselves not only on the basis of their personal identity (their unique individual characteristics and relationships) but also on the basis of their social identity (the experience of group membership) (Abrams & Hogg, 1990; Ashforth & Mael, 1989; Giessner, Ullrich & van Dick, 2012; Ullrich, Wieseke & Dick, 2005).

Social identity theory. Individuals gain their social identity from the groups to which they perceive themselves as belonging (Kane, 2010). According to the social identity theory, people classify themselves into various social categories, such as organizational membership, gender, and age (Ashforth & Mael, 1989). Within the literature on social identity theory, Tajfel and Turner (1979) defined a group as "*a collection of individuals who perceive themselves to be members of the same social category, share some emotional involvement in this common definition of themselves, and achieve some degree of social consensus about the evaluation of their group and of their membership of it*" (p. 40). When people

identify themselves with a group, and they experience a sense of pride in it, they view their group as positively distinct from others (Tajfel & Turner, 1979).

Organizational identification. According to Ashforth & Mael (1989), organizational identification is a specific form of social identity. Organizational identification is the perception of belongingness to an organization, in which individuals define themselves in terms of the organization to which they belong (van Knippenberg, van Knippenberg, Monden, & Lima, 2002; Ullrich, et al., 2005). Moreover, individuals do not derive their social identity solely from their organization, and one's work group, department, union, or lunch group (Ashforth & Mael, 1989) are other sources of social identity. Within organizations, a strong, shared identity among (team) members has been linked to reduced (interpersonal) conflict. In the absence of such an identity, team members are likely to negatively evaluate their colleague's behavior, resulting in a competitive—rather than cooperative—environment in which problems and miscommunications arise (Hinds & Mortensen, 2005). High levels of identification benefit organizations in many ways, including performance gains and higher motivation and job satisfaction on the part of employees (van Dick, Ullrich & Tissington, 2006; Ullrich et al., 2005).

Mergers and social identity

A special case of social identity concerns the merger of two organizations, which incorporates changes to group membership (van Knippenberg et al., 2002). The existing literature contains many examples of failed mergers due to employees' resistance to relinquishing their old identities (Hogg & Terry, 2000). In such situations, employees often identify with their pre-merger organization and perceive the other firm as a potential "enemy" (Giessner, et al., 2012). This identification with the pre-merger organization hinders the merging process and creates the potential for conflict, competition, and discrimination (Gleibs, Noack & Mummendey, 2010).

Sense of continuity. Employees know that changes are sometimes unavoidable, but they generally want to feel as though they continue to work for the same organization (Giessner, et al., 2012). Thus, employees need a sense of continuity, and they are more likely to transfer their sense of identification to the post-merger organization when they only see few changes in their daily work (Giessner, et al., 2012; van Dick et al., 2006; Ullrich et al., 2006). However, when there is discontinuity (e.g., a move to new location, a change to the organizational culture, or the introduction of a new management team), employees are less likely to transfer their former identification to the new organization (van Dick, et al., 2006; van Knippenberg et al., 2002; Ullrich et al., 2005).

In summary, building upon these five theoretical bases, understanding needs to be gathered about the relationship between micro-mergers and their outcomes. In the next section, the methodology used in this paper is described.

METHODOLOGY

Since the field of micro-merger research is still young, a case study constituted the most appropriate approach for studying the phenomenon of micro-mergers within PSFs. Therefore, this study was based on the theory-building approach, with qualitative research well-suited for understanding phenomena within their context, uncovering links among concepts and behaviors, and generating theory (Miles & Huberman, 1994).

Case selection

This multiple-case study examined the mergers of three outpatient departments within UMCG. These departments were the following: (1) Cardiovascular Diseases, (2) Abdominal Medicine, and (3) Oncology. This last department is also known as Comprehensive Cancer Center (CCC) Groningen. The three cases all represent a form of micro-merging within UMCG. The main inclusion criterion stipulated that cases needed to have fully completed the merging process, so that they could provide an overview of process' outcome. In addition, the cases were chosen on the basis of the incentives to merge that they presented and their objectives. Therefore, the outpatient department Cardiovascular Diseases was selected, because the Thorax Center and Vascular Surgery (including a vascular laboratory) were involuntarily merged, although they did not have a history of collaborating. Likewise, the outpatient department Abdominal Medicine was also the result of an involuntary merger. However, the physicians from both disciplines (the Gastrointestinal and Liver and Abdominal Surgery) already collaborated before they were merged into the new outpatient department. The third case was CCC, since its merger was initiated by the department itself with the goal of encouraging collaboration between all providers focused on oncology.

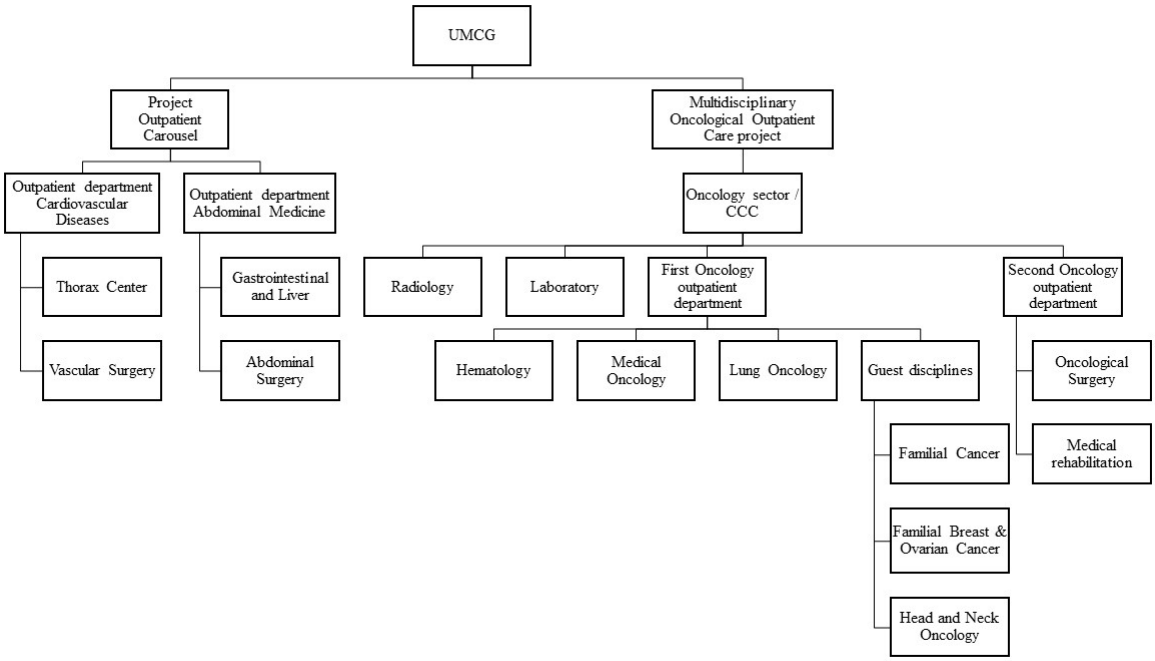
Project definitions

The three cases of micro-mergers within UMCG emerged from two projects within UMCG (see Figure 1). The first project is called "Outpatient Carousel". This project emerged because of another project, called "Operation Hotfloor". The project "Operation Hotfloor" is the renovation and expansion of the operation rooms, the intensive care department, and the expansion of the emergency department within UMCG. To be able to realize "Operation Hotfloor", UMCG needs to rearrange the outpatient departments within UMCG. By rearranging the outpatient departments, UMCG does not need to expand. This rearrangement is referred to as Project Outpatient Carousel. This project sought to achieve a new, patient-oriented division of the outpatient departments. Grouping disciplines in a patient-centered way, UMCG is divided into seven clusters. These are focused on the following specialties: the head, the body, movement and mobility, the pelvic region, cardiovascular medicine, and children's medicine. This project resulted in formation of the Cardiovascular Diseases and Abdominal Medicine outpatient departments.

The second project in this paper is called the Multidisciplinary Oncological Outpatient Care project. This project was rooted in a shared, intrinsic desire to provide high-quality care to certain groups

of oncological patients. Previously, different departments had been responsible for oncological care. The goal of the Multidisciplinary Oncological Outpatient Care project was to create a center or an outpatient department where (1) physicians could see patients (2) treatment is close to the outpatient department. Therefore, in 2007, UMCG established an Oncology sector which, in turn, consists of different departments. Until the start of Project Outpatient Carousel, UMCG was divided into sectors, each with its own management and each own departments. Since 2015, the Oncology sector changed into CCC.

FIGURE 1
Visual chart micro-mergers within UMCG



Case description

Cardiovascular Diseases. In March 2016, the Cardiovascular Diseases department opened. It merged the Thorax Center–consisting of the disciplines Cardiology and Cardiothoracic Surgery–with Vascular Surgery (including a vascular laboratory). Until that point, these two disciplines had not cooperated in any way. Beginning in March 2016, the vascular surgeons, the vascular laboratory, and three medical administrative assistants (MAAs) from Vascular Surgery merged with the Thorax Center into the new Cardiovascular Diseases department.

Abdominal Medicine. In April 2016, the Abdominal Medicine department opened, making it the second new outpatient department to be realized by Project Outpatient Carousel. Within the Abdominal Medicine department, the Gastrointestinal and Liver discipline was merged with Abdominal Surgery. This new department received a small workspace, that was not suitable for other disciplines within UMCG. The Gastrointestinal and Liver specialists were pleased with the merger, since they had been spread across multiple UMCG departments before the reorganization. However, they remained spread across UMCG, including the Transplantation Center and the Oncology Center. Additionally, the Abdominal Medicine surgeons and the Gastrointestinal and Liver physicians had already cooperated with each other prior to the merger.

Comprehensive Cancer Center (CCC) Groningen. Due to the way the Oncology sector was established, the department heads, medical staff, researchers, and other Oncology staff members came to believe that UMCG needed a cancer center to bring together all providers of cancer care. This conclusion was the logical continuation of many discussions, documents, organizational changes, and developments within and outside of UMCG. Therefore, in October 2015, CCC was established. CCC brought together the following disciplines: Medical Oncology, Hematology, Lung Oncology, Familial Cancer (Clinical Genetics), Oncological Surgery, the Familial Breast & Ovarian Cancer Clinic, and the "tumor group" Head and Neck Oncology.

Since the CCC was founded, work has begun on an oncology plaza, which will consist of two Oncology outpatient departments, Radiology, a laboratory specializing in blood tests for cancer patients, an information center for patients, and a space for young cancer patients to connect with each other. Of these two outpatient department, the first oncological outpatient department consists of Medical Oncology, Hematology, and Lung Oncology. Moreover, Clinical Genetics and Head and Neck Oncology also belong to that department. The second outpatient oncological department will consist of Oncological Surgery (Gastrointestinal Oncology and Gynecological Oncology) and medical rehabilitation. This second Oncology outpatient department is still being developed. Therefore, this study only focused on the merging of the disciplines into the first Oncology outpatient department.

Data collection

Data on the three cases was gathered from both semi-structured interviews and documents. The interviews provided most information, while document analysis yielded some secondary data. Semi-structured interviews were selected, as they offered a flexible means of conducting individualized interviews still collecting all required information (Noor, 2008). The use of two different data-collection techniques permitted the author to more reliably confirm the results (Eisenhardt, 1989).

The semi-structured interviews were conducted in two phases. First, five exploratory interviews provided the author with insights on the three cases and yielded information about Project Outpatient Carousel and the Multidisciplinary Oncological Outpatient Care project. Based on these exploratory interviews, 16 in-depth interviews were held with individuals who had played a role in the three cases, with an average of five interviews per case. Within each case interviews were held with the outpatient department manager and the medical administration manager. Furthermore, interviews were held with location specific personnel. Both the exploratory and in-depth interviews were conducted in Dutch and lasted for approximately one hour. Table 1 contains an overview of the three cases and the interviews. Of these 16 in-depth interviews, three general interviews gave a better understanding of Project Outpatient Carousel and the Multidisciplinary Oncological Outpatient Care project. In addition, documents such as UMCG's internal newsletter provided general information about Project Outpatient Carousel.

TABLE 1
Overview of the three cases

	Cardiovascular diseases	Abdominal	Comprehensive Cancer Center (CCC)
Incentives to merge	Involuntary, due to Project Outpatient Carousel	Involuntary, due to Project Outpatient Carousel	Own desire to cooperate to improve oncology-focused care
Collaboration	No collaboration at all	Some form of collaboration between physicians	Strong incentives to collaborate
Total number of in-depth interviews	5 interviews	6 interviews	5 interviews
Documents	Policy plan: 1 Implementation plan: 1 UMCG intranet Outpatient Carousel newsletter	Policy plan: 1 Implementation plan: 1 UMCG intranet Outpatient Carousel newsletter	Policy plan: 1 Oncology within UMCG brochures: 3 UMCG intranet

The interview protocol is located in Appendix A. The questions were based on theoretical background information on merging processes, as outlined in the literature review. Throughout the data collection process, the interview protocol was adjusted by refining the questions and/or adding and removing questions. During the interviews, questions were asked in a random order, and the author also raised additional questions exploring emergent issues. Therefore, the respondents did not all answer the same questions.

To ensure that the primary and secondary data were reliable, the author relied on van Aken, Berends and van der Bij's (2012) quality criteria. The controllability of this study was ensured by explicitly describing the methodology and writing memos throughout the process. Thus, other researchers will be able to replicate this study (van Aken, Berends & van der Bij, 2012). Reliability was ensured by considering four potential biases (van Aken, Berends & van der Bij, 2012). In order to limit the researcher bias, the author recorded all interviews and took notes during them. The recordings allowed the author to listen to the interviews again and transcribe them at a later date. The advantage was that the author did not have to take many notes during the interview and thus did not miss any important information. To control for an instruments bias, this case study relied on multiple data sources (i.e., interviews and additional documents). The study controlled for a respondents' bias by only including interviewees who had been involved in the micro-merging process. To control for a circumstantial bias, the interviewees were interviewed at different times and on different days. The interviews were conducted in a quiet room, and so their colleagues could not influence their answers. This helped to avoid a situation in which the interviewees felt pressured to give politically correct answers (van Aken, Berends & van der Bij, 2012).

Data analysis

Data analysis was carried out iteratively with data collection. Each interview was transcribed as quickly as possible. All interviews were analyzed by reading, coding, and interpreting them individually. When analyzing the transcripts, the main focus was on identifying and coding unique and relevant findings. The coding process utilized Atlas.ti software, which is designed for qualitative data analysis. At the outset of the process, the author began with certain coding categories, such as the merging process, its consequences, and its outcomes. After establishing these overarching categories, more detailed coding brought in categories such as standardized way of working and quality improvements. Thus, the data analysis process moved back and forth between purging, coding, and analyzing.

When the coding process was complete, the author began by putting together a write-up for each case. These simply described the micro-merging process within UMCG. The secondary sources were analyzed separately from the interviews. After the within-case analysis, the cases were compared to each other, and conclusions were cross-checked against the interview transcripts. During the within-case analysis, different types of micro-mergers were identified at the department and subgroup levels. The merger of the different disciplines into the new outpatient departments is seen as a micro-merger on department level. The merger of the MAAs of the different disciplines within the new outpatient departments is seen as a micro-merger on the subgroup level. Then, during the cross-case analysis, these various types of micro-mergers were compared to each other in terms of their objectives, team structures, and outcomes.

RESULTS

Thus, this paper is based on twenty-one semi-structured interviews and some secondary data on the micro-mergers within UMCG. After analyzing the within-case analysis, a cross-case analysis was undertaken. This chapter describes the key findings derived from the semi-structured interviews and analyzed secondary data. This results section consists of six sections. Hereby, the motives for merging, the merging syndrome, social identity, equivalency, improved healthcare quality, and standardized way of working are described.

Motives for merging

The motives to merge differed across fields. Although Project Outpatient Carousel forced Abdominal Medicine to form, the involved disciplines were pleased with the merger. However, the specialties comprising Cardiovascular Diseases, which Outpatient Carousel also compelled to merge, were not as satisfied with the outcome. As one of the respondents pointed out: *"In the beginning, we were told that Vascular Surgery, including the vascular laboratory, was moving in…For a second, we thought, 'Forget it! We are not really going to do that.' We already had the best occupied department within UMCG, and then we also needed to share…".* When comparing CCC to the other two outpatient departments, the incentives to merge were completely different. While Project Outpatient Carousel forced the other two mergers, the CCC arose from the shared desire to provide high-quality care for certain groups of

oncological patients. Therefore, at the physician level, members of the Abdominal Medicine outpatient department and CCC always had an interest in working together. However, within Cardiovascular Diseases, that desire did not exist, as those physicians did not cooperate at all when it came to patient care.

Merging syndrome

The various specialties differed in terms of their first reactions to the merging process. Within all of the outpatient departments, there was some staff unrest, especially among the MAAs because the mergers had the greatest impact on their work. However, during the first phase of Outpatient Carousel, the steering committee of Outpatient Carousel exhibited little to no concern for the employees. In particular, the MAAs experienced feelings of fear. The mergers aggravated longstanding emotional issues that had arisen a few years back concerning MAA assessments. The MAAs needed to pass these assessments to check whether they were suitable to work with the electronic health record, with regard to its introduction in 2017. This generated a lot of fear concerning the reorganizations, because, according to one of the respondents, *"the old scars are still fresh in their mind."* However, the transition to the new outpatient departments turned out to be a gradual process, and no staff members were laid off.

In terms of the outpatient departments' initial reactions, the Abdominal Medicine department was pleased, while Cardiovascular Diseases was not. Cardiovascular Diseases first indicated to the Outpatient Carousel steering committee that it would not fit in the new outpatient department. The Thorax Center already had the best occupation within UMCG and did not want to share its outpatient department.

Fortunately, within the Abdominal Medicine department, space was not an issue. As one of the respondents explained, *"I mean, you always prefer something and more space, etcetera, but I think if you know where you come from, then that is less of an issue. If you naturally have a lot to give, then you perceive it as a big loss. However, if you 'had nothing,' well, then it is all beneficial."*. Members of the new Abdominal Medicine department had already cooperated on patient care one day per week. Therefore, it was not entirely foreign for the two disciplines–the Gastrointestinal and Liver discipline and the Abdominal Surgery discipline–to work within the same department. Although they were forced to merge into the Abdominal Medicine department, the Gastrointestinal and Liver specialists were glad to have their own outpatient department. Prior to the merger, they had been forced to work around other departments' schedules.

On the other hand, all those involved in cancer care desired the construction of CCC. Although there was some resistance regarding formally moving into CCC (from, among others, the Surgery department and the Internal Medicine department), all disciplines saw the added value of moving their oncology-related consultations to the Oncology department. Thus, remarkably, although CCC was fully voluntarily, not everyone was satisfied with it. All of the specialists involved in oncological care supported the CCC's underlying ideas and vision. However, after the establishment of the Oncology Sector, which later resulted in CCC, not all disciplines formally proceeded to that sector. However, they

did want to make use of the Oncology outpatient department and participate in multidisciplinary endeavors (e.g., participation in tumor groups–multidisciplinary groups of healthcare providers who specialize in the diagnosis, treatment and aftercare of patients with specific kind of tumors–and the multidisciplinary consultation hours) because they saw the added value of improving oncological care. However, the disciplines did not want to formally merge into the Oncology outpatient department, which meant leaving their own departments. Therefore, the Oncology outpatient department consisted of many disciplines, but only three departments (Hematology, Medical Oncology, and Radiotherapy), left their previous departments for the new Oncology department within UMCG.

Equivalency

In terms of the power differential between the disciplines that merged into the new outpatient departments, despite their large differences in size, they had the same amount of power. All of the disciplines worked to achieve an appropriate balance of power within their new departments. For example, Cardiovascular Diseases gave Vascular Surgery, its smallest discipline, a powerful voice, making the Surgery department's head nurse the chair of the new department. According to the staff of the Thorax Center, the key to successful cooperation within Cardiovascular Diseases was favoring the guest, Vascular Surgery.

At the Abdominal Medicine department, the largest field, Gastrointestinal and Liver, gave Abdominal Surgery staff members the feeling that they were equals. However, considering the social identity of the physicians working in the Abdominal Medicine department, it was remarkable that the surgeons, for example, never attended the department's user council meetings.

At CCC, power differences have never been the case, and everyone is equal. Instead of assessing individual contributions, the various disciplines tried to act like a cancer center, with their eye on the bigger picture.

In summary, although the merged disciplines differed in size in all three cases, no power differences existed. However, approaches to encouraging a sense of equality varied across the cases.

Communication. Keeping people informed and letting them carefully consider important decisions was quite important during the micro-merging process. One of the managers stated that, *"It is a very good idea to ask people how they feel about some things with which they are involved during the process. People always find it nice to be heard and know that it is what it is, but to have the feeling that they thought of certain things."*. Therefore, communication and clarity are essential, because they provide peace and certainty.

By providing a lot of information, conducting individual meetings, and gauging interest (especially among the Surgery department's MAAs), Project Outpatient Carousel avoided a formal reorganization whereby staff members are laid off. With regard to the Surgery Department's MAAs, the Surgery department's medical administration manager calculated the number of Full-time equivalent (FTE) to be spread over the new outpatient departments. This led to an organic discussion of which

MAAs wanted to transfer to which outpatient department. Therefore, the transition to the new departments was gradual, and no staff members were laid off.

During the merging process, it was important to keep all of the staff informed and to give them a sense of authority. Cardiovascular Diseases kept its staff informed by discussing ideas with the daily managers, while the Abdominal Medicine gave official presentations, held staff meetings, and shared plans with their staff. Also during the development of the first Oncology department, involving all stakeholders was essential. Patients, nurses, physicians, medical administrators, and all other departmental staff members played a role. Therefore, the plans were presented for the new Oncology department on a schedule that permitted all interested parties to attend. Also, the staff received a brochure about CCC and the intended changes, and that document helped to reduce uncertainty.

Feelings of unity

Initially, it was not clear that Project Outpatient Carousel would have such a significant effect on the employees, and especially the surgical MAAs, who were spread across all of the new outpatient departments. The Surgery department allowed its MAAs to work for eight weeks within the new outpatient departments before deciding whether the MAAs wanted to "move" there. Although this took a lot of time and energy, it meant that the staff from the Surgery department were spread across the new departments as organically as possible. However, the surgical MAAs still indicated that they did not feel that they were part of a new team, and they have faced feelings of homesickness since the move. Still, the Surgery department's medical administration manager was strongly committed to finding suitable placements for all of her MAAs. Therefore, she kept in touch with her MAAs and will remain their manager until the end of Outpatient Carousel, at which point all of the MAAs will be formally employed by another outpatient department.

Although the MAAs from the Surgery department received very warm welcomes in all of the outpatient departments, some differences existed regarding social identity. Three MAAs from Vascular Surgery merged into the new Cardiovascular Diseases department, and so they could rely on each other. However, they still found it difficult to be placed into a larger group of MAAs in another department. Although the MAAs work in Cardiovascular Diseases department, both groups MAAs kept to themselves "on their own small islet." Although they work side by side within the same outpatient department, they do feel that they are a team.

Regarding the Abdominal Medicine outpatient department, the MAAs comprising that new unit had already worked together. For the Gastrointestinal and Liver discipline, the merger simply meant moving to a new outpatient department and acquiring new colleagues from Abdominal Surgery. During the first weeks, the MAA of the Abdominal Medicine surgery was seen as a new colleague. According to one of the respondents *"These people deserve credit because standard, I always receive the same feedback, 'Gosh, they accommodated me well. I felt very welcome'."*. However, in retrospect, they thought of the merging process too easy. As one of the respondents stated, *"We are going to work together, that's fantastic! We work together, there has never been so much misery, and everything is*

wrong here.". Only one MAA from Abdominal Surgery moved into the new outpatient department. Unfortunately, she only wanted to work within Abdominal Medicine by only working for her previous discipline. Although she already knew her new colleagues, that MAA had been forced to leave familiar surroundings. Therefore, another MAA member from the Surgery department's medical administration team offered to try to work in the new Abdominal Medicine department. On the other hand, since the merger, the Gastrointestinal and Liver MAAs have truly felt part of the new department. Both the MAAs and the physicians frequently mentioned the increased contact between them. There is a big difference between serving a physician from the outpatient department and serving a physician from a back office at another location within UMCG. Since the merger and the formation of the new outpatient department, the physicians and MAAs see each other more often. Thus, their communication has improved, as has their feeling of belonging to the same team.

Within the first Oncology outpatient department within CCC, social identity and team structure differed from the other outpatient departments. In particular, the formation of the first Oncology outpatient department meant that the MAAs from Hematology, Medical Oncology, and Lung Oncology started working within it. In contrast, MAAs from other disciplines work elsewhere within UMCG. They are only present at the Oncology outpatient department during the consultation hours of their discipline. The three key disciplines became one team because the MAAs worked for all these three disciplines. However, because the Oncology department became too large and too specific, it has been split into three different teams since 2014, and the MAAs now work within a single field. Moreover, the physicians working within the Oncology department provide clinical trainings a few times a year for these MAAs, which has increased their motivation levels. Other disciplines that offer consultation hours at the Oncology outpatient department on certain days cannot be considered as part of the team, at least not at the MAA level. As a result, the MAAs of the three key disciplines–Hematology, Medical Oncology and Lung Oncology–know the MAAs of the other disciplines and share a workspace, but do not actually work with the other disciplines. However, it is not the case that the other disciplines feel unwelcome within the outpatient department.

Team structure. When creating a new outpatient department, it is important for the MAAs to learn the new working procedures following the merger. The MAAs must feel that the new department unites its constituent fields instead of simply housing various specialties in the same physical location. Especially when it comes to patient services, the MAAs' working procedures must be merged in a way that permits the front desk to serve all of the department's patients.

However, in terms of team structures, all of the cases differed from each other. Within Cardiovascular Diseases, employees from different fields shared a space but continued to do their own work. In contrast, the Abdominal Medicine outpatient department merged the working procedures of the Abdominal Surgery MAAs and the Gastrointestinal and Liver MAAs. Thereby, for now, the MAAs from those two disciplines need to be able to stand in for each other when needed. Eventually, all MAAs will be working for both disciplines. Regarding CCC, the three main discipline constitute one team, and so the MAAs at the Oncology department can work across that department's disciplines. However,

because of the number of fields that the Oncology department encompasses, it has sought for MAAs to specialize in a single discipline. Furthermore, the remaining disciplines of the Oncology outpatient department are not part of the team.

Team identification. Cooperating on delivering high-quality healthcare enhanced the social identity of those individuals who felt that they belonged to a new multidisciplinary team. Those multidisciplinary team members felt unique in relation to both the rest of UMCG and other healthcare providers. For example, CCC delivers high-quality care for oncological patients and is also one of the largest research institutes in the northern Netherlands. A respondent explained as follows: *"I think social identity can be perhaps derived from uniqueness. I am special, because…that is what people like about a particular discipline. And often, people derive their identity from a particular discipline, I guess."*.

Identification by the surrounding environment. The results indicated that the surrounding environment, which recognized the new outpatient departments within the cases as one group, helped to form its social identity. However, before being recognized as a group, the constituent disciplines must cooperate within the outpatient department. A respondent explained this phenomenon as follows: *"…social identity arises when the surrounding world says you're one group. And, of course, you can tell much easier that they are one group, as they also work together. The surrounding world is not going to recognize the outpatient department as one group when two desks exist where they need to go. So, there is a strong interaction.*".

Improved healthcare quality

The ultimate aim of Outpatient Carousel was to create more space for "Operation Hotfloor" and create a patient-centered healthcare model. The ultimate aim of CCC was improving oncological care. As the new departments aligned the working processes of their constituent disciplines and jointly formalized policies, they worked towards improved patient care.

At the Abdominal Medicine department, healthcare quality improved. However, during the first months after the merger, healthcare quality initially declined slightly, as the department's disciplines had to learn to work with each other. CCC also saw healthcare quality improve dramatically. However, although the interviewees mentioned that healthcare quality improved at most departments, one of the respondents noted, *"Honestly…At some outpatient departments, it yielded absolutely nothing. At the Abdominal Medicine department it did...So that is good. However, Cardiovascular Diseases…The board of directors may think they are very close to each other in the body, but for patient care, we do nothing together."*. However, although members of Cardiovascular Diseases did not cooperate on patient care, the merger ultimately gave that department's staff a vision of working together on patient care in a more flexible way in the future. Thus, the micro-merging process did not directly enhance healthcare quality but indirectly revealed areas for improvement.

At the Abdominal Medicine department and CCC, patients can pass through the care process more quickly, because healthcare is centered around specific disciplines, thus necessitating standardized working procedures. Also, the more intense and multidisciplinary cooperation and the intention of the

different disciplines to learn from each other led to better healthcare. One of the respondents explained, *"we are now more like one team, because we all sit together, and I think it will benefit healthcare in each area."*. The outpatient department physicians can now reach each other more quickly.

Therefore, the mergers made multidisciplinary cooperation easier by speeding inter-disciplinary communication. As a result, referrals to other disciplines run more smoothly. A respondent indicated that, *"the most positive outcome… [is that] the employees, they look beyond their own discipline more...Now there is more bonding with other disciplines."*. Moreover, a respondent claimed that, *"when you cooperate with so many other disciplines, then you dare to look beyond boundaries."*. However, some of the new outpatient departments did not cooperate on patient care, because they brought together specialists from vastly different fields. For example, although they deal with similar body parts, the disciplines within Cardiovascular Diseases are completely different from each other, and cooperation and multidisciplinary patient care were thus inappropriate. These mergers simply resulted from the need to create space within UMCG for "Operation Hotfloor".

Standardized way of working

Within UMCG, each outpatient department was a small hospital in itself. Each shared the same values, strategy, and overarching objectives as the rest of UMCG but with its own responsibilities, policies, and working procedures. Although each discipline working methods differed, many elements of care could be standardized across UMCG.

As previously mentioned, in the long term, the MAAs from each discipline will need to learn the working procedures of MAAs from other disciplines. Therefore, UMCG needs to develop standardized procedures. However, it should not underestimate the differences between the disciplines. Most of the respondents indicated that, *"Eighty percent of our process is uniform, and the remaining twenty percent is different."*. Thus, although some disciplines share similarities, some working procedures differ from each other in terms of privacy, treatments, and guidelines covering the speed at which patients should receive treatment. That means that while disciplines should adopt standardized procedures where possible, they must be able to adapt those procedures to meet their specific requirements. Therefore, during Outpatient Carousel, the Healthcare Logistics and Medical Administration Workgroup was formed to addresses cross-disciplinary differences regarding working procedures. This workgroup created a vision for a standardized way of working, and it especially emphasized healthcare logistics and the medical administration processes. This advisory document is still awaiting approval from the board of directors, sector executives, and the department heads. However, not everyone is in complete agreement with the advisory document, as one of the respondents explained: *"I think that the principle underlying this basic idea is very good. I think we should be pursuing this goal. I just wonder whether it is possible to compare a gerontology department with a children's department. I think that you should not be wanting to work in the same way."*.

Reduced routinization. To achieve standardized working procedures, the organizational routines of each discipline must change. Before the micro-merging process, the disciplines were

completely unfamiliar with each other's procedures. Nonetheless, the mergers forced some of them to quickly adopt new approaches. For example, only one Abdominal Surgery MAA moved into the Abdominal Medicine department, which meant that MAA could no longer rely on previous working procedures. Therefore, the first step was to ensure that the Gastrointestinal and Liver MAAs could stand in for the Abdominal Medicine Surgery, for example, in the case of illness.

Fortunately, not all disciplines were forced to adapt a new way of working. Cardiovascular Diseases initially decided against making revolutionary changes regarding cooperation on patient care. Instead, the two constituent disciplines remained separate within the new department. One of the respondents explained, *"We just waited to see what would happen, where we could integrate both disciplines. And that happened spontaneously."* In other words, although two disciplines worked within Cardiovascular Diseases, they both remained "on their own small islet". For now, the MAAs of the different disciplines carry out only the simple tasks for each other. However, the ultimate goal is for MAAs from both disciplines to work throughout the entire Cardiovascular Diseases department.

As compared to Cardiovascular Diseases and the Abdominal Medicine department, CCC's working procedures are considerably different. After moving into the Oncology outpatient department, the Hematology, Medical Oncology and Lung Oncology disciplines started working together as one team. However, because CCC became too large and too specific, it again split into three dedicated teams, although members can still replace each other as needed (e.g., in case of illness). The difference between CCC and the other two outpatient departments is that other disciplines also work at CCC, bringing their own staff to the front office only when needed.

Consequently, team structures vary widely across these outpatient departments. For example, MAAs within both Cardiovascular Diseases and CCC are dedicated to a particular discipline, while Abdominal Medicine department MAAs work for both fields.

Governance. After the mergers, the remaining disciplines retained their respective managers. Therefore, for each new outpatient department an outpatient department manager was chosen. The outpatient department managers works jointly with the outpatient departments' head of the physicians, who is responsible for supervising the physicians. However, the outpatient department Cardiovascular Diseases chose to see the outpatient department manager as a task of one of the managers rather than as a new position within the outpatient department. Moreover, each new department has an users council that meets once a month to ensure that all disciplines can speak up about departmental actions. In this way, all disciplines are treated as equals, despite their differences in size. In most outpatient departments, the outpatient department manager, representatives of all disciplines (mostly medical administration managers), and the head of the physicians have joined the users council.

Policy. Another consequence of the micro-merging process was that the disciplines needed to adapt to each other's working procedures, work towards standardized procedures, and let go of their own policies. For example, the Surgery department's staff members were spread across the new outpatient departments, even though they had their own policy plan for providing higher-quality

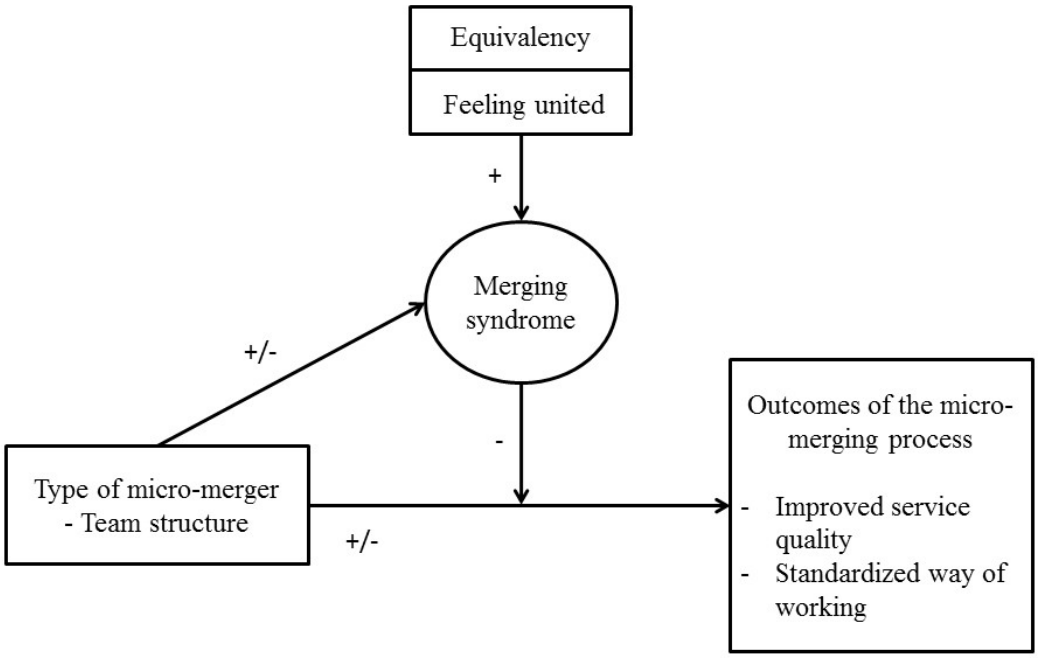
healthcare. Now they have been transferred to the new outpatient departments, report to the new outpatient department managers, and follow a new policy plan.

DISCUSSION

In this chapter, a discussion and a literature reflection will be presented regarding the key findings derived from the semi-structured interviews and the analyzed secondary data. Drawing on the key findings of the case studies, the author proposes a conceptual framework detailing the PSF micro-merging process (see Figure 2). This chapter discusses that model, connecting it to the research question: **How do different types of micro-mergers affect the performance of PSFs?** Furthermore, these key findings lead to propositions on the topic of micro-mergers.

FIGURE 2

The relationship between different types of micro-mergers and their outcomes



Type of micro-merger

Micro-mergers within PSFs can fall into various categories. Napier's (1989) earlier research on M&As established a typology for mergers on the firm level. Although this paper's analysis focused on a different level of analysis, Napier (1989) classification system (extension mergers, collaborative mergers [synergy mergers and exchange mergers] and redesign mergers) is applied at the department level and the subgroup level.

Napier's (1989) framework suggests that a firm's motives and characteristics can have an effect on the type of merger it pursues. On that basis, different types of micro-mergers are identified.

In accordance with Napier (1989), CCC represented a collaborative merger (both synergy and exchange) and an extension merger. First, CCC constitutes a synergy merger, because its three main disciplines compromised on blending their operational functions but did not fully integrate managerial

functions. Lung Oncology and other users of the Oncology Outpatient Department did not formally become part of the Oncology Sector. Thus, although the three main disciplines cooperated in delivering high-quality patient care, the remaining disciplines were not part of the Oncology Sector when it came to governance. Therefore, CCC can also be seen as an extension merger, since the Oncology department's remaining disciplines were not incorporated in terms of their operational and managerial functions. Moreover, because all those involved in cancer care desired the formation of the CCC, it also represents an exchange merger, as CCC physicians and MAAs exchange knowledge and expertise.

The Abdominal Medicine outpatient department constitutes a joint redesign/collaborative (synergy) merger. Both constituent disciplines benefited from merging into the new departments and cooperating on patient care. In addition, the Abdominal Medicine outpatient department blended the operational and managerial functions of both disciplines. Regarding that department's MAAs, the Gastrointestinal and Liver MAAs have adopted the policies and practices of the Abdominal Surgery MAA. Eventually, the MAA Abdominal Surgery will also adopt the operational routines of the Gastrointestinal and Liver MAAs.

Cardiovascular Diseases can be seen as an extension merger, because the disciplines, and especially the Thorax Center (the acquiring discipline) did not intend to change. Regarding the MAAs, both disciplines maintained their own working procedures. Although they now intend to integrate front-office processes, this was not their initial objective.

Team structure. Earlier research on M&As indicated that merging into a new entity means a change to group membership (van Knippenberg et al., 2012). Depending on the type of merger and its objective, the creation of new teams can bring major changes (Napier, 1989). In line with Napier (1989), this study found that team structures did not change in cases of extension mergers, with the acquired disciplines becoming an extension of the existing outpatient departments. In those cases, the acquired disciplines performed at a high level and added to the acquirer's assets, without requiring management input from the acquiring discipline.

Regarding team structure within collaborative and redesign mergers, they changed to achieve the purpose of those mergers. For collaborative mergers, in line with Napier (1989), the disciplines adopted each other's working procedures, knowledge, and skills. Thus, as Napier (1989) suggested, in particular the Oncology outpatient department had to develop new policies that fit the existing disciplines. However, in contrast to Napier (1989), although employees were familiar with other disciplines' working procedures and thus could fill in for each other, they still specialized within one field within their department.

During the redesign merger, the acquiring (largest) discipline began by learning and adopting the working procedures of the acquired (smallest) discipline. Thereafter, the acquired discipline adopted the working procedures of the acquiring discipline, and the two became one team from that point onwards. Therefore, the redesign merger led to new working procedures for both disciplines. In contrast, Napier (1989) stated that redesign mergers bring more changes for the acquired entity than extension and collaborative mergers, because the acquired entity must become more similar to the acquirer, which

implies adopting its policies and procedures. Although the changes in the acquired discipline did outweigh the changes in the acquiring disciplines, the latter began by learning the working procedures of the former. Moreover, in line with Napier (1989), the redesign micro-merger led to greater changes in the acquired discipline than did the extension and collaborative micro-mergers. However, in contrast with Napier (1989), both disciplines adopted the policies and procedures of the acquired discipline. Therefore, considering Napier's (1989) findings and the three cases, the following propositions are established:

Proposition 1. Team structures do not change after an extension micro-merger.

Proposition 2. Team structures do change after collaborative and redesign micro-mergers.

Proposition 3. Redesign micro-mergers lead to greater changes in team structures as compared to collaborative micro-mergers.

> *Proposition 3a. Redesign micro-mergers lead to changes in team structures in both the acquiring and acquired disciplines.*
>
> *Proposition 3b. Redesign micro-mergers lead to greater changes in team structures for the acquired disciplines than the acquiring discipline.*

Outcomes of the micro-merging process

The micro-merging process results in two outcomes. Performance rises (as measured in terms of service quality), and standardized procedures also are established, thus reducing routinization.

Increased performance. The ultimate goal of the micro-merging process within PSFs should be improving the quality of the professional service provided. Prior research by Agarwal et al. (2003) on enhancing service has indicated that customer and employee satisfaction play a key role in firm performance. Therefore, this study measured healthcare quality in terms of the satisfaction levels of outpatient department employees and their perceptions of whether healthcare quality had improved post-merger.

According to Napier (1989), the type of merger and human resources practices are connected to a merger's outcomes, such as the firm's (financial) performance. When investigating healthcare quality, the cases demonstrated that the extension merger did not lead to improved healthcare quality, although the collaborative and redesign mergers did. Thus, the cases suggest that collaborative and redesign micro-mergers enhance the performance of PSFs, while extension mergers do not. However, this study did not suggest that extension mergers cause declines in performance; rather, performance remains constant.

In contrast, Napier (1989) claimed that extension mergers might boost the performance of firms that had already been performing at a high level, due to the additional available resources. In addition, Napier (1989) noted that collaborative mergers could trigger initial drops in performance. However, in this study, the redesign merger enhanced performance, although an initial drop was indeed evident. The collaborative mergers led to increased performance. Thus, the results support Napier's (1989) assertion that the merging process can lead to performance declines before performance increases become

apparent. However, this paper only confirmed that finding for redesign mergers and not for collaborative mergers. This suggested the following propositions:

Proposition 4. Extension micro-mergers lead to neither performance increases nor declines for PSFs.

Proposition 5. Collaborative micro-mergers lead to performance increases for PSFs.

Proposition 6. Redesign micro-mergers lead to performance increases for PSFs.

Proposition 6a. Redesign micro-mergers can initially lead to performance declines for PSFs.

Standardized way of working. The results indicated that the departments needed to move towards standardized, patient-centered processes to generate performance increases. This meant changes to organizational structures, policies, procedures, and routines (Appelbaum et al, 2000). Eventually, to achieve a standardized way of working, the disciplines will have to adopt each other's working procedures and routines, which will improve overall service quality. However, considering the different types of micro-mergers within PSFs, not all cross-discipline policies and procedures can be standardized. As the cases reveal, while some disciplines might share similarities, their procedures can exhibit differences in, for instance, privacy and treatment guidelines. Nevertheless, in the long run, within all of the outpatient departments, the disciplines will need to adapt to each other, which will sometimes mean relinquishing their own policies, procedures, and routines.

Giessner, et al. (2012) explained that even if employees know that organizations have to change, they generally want to feel a sense of continuity and perceive few changes in their daily work. Therefore, the argument can be made that reduced routinization should not be taken lightly, because it changes work relationships. The cases demonstrated that during extension micro-mergers, employees perceived almost no changes in their daily work routines. In contrast, the collaborative micro-merging process led to moderate changes in employees' work routines, while the redesign micro-merger led to significant perceived changes. Therefore, the results supported Napier's (1989) conclusion that extension mergers tend to result in minimal changes regarding human resources practices, while collaborative mergers may have extensive effects on human resources practices for both parties. However, the results did not support Napier's (1989) assertion that redesign mergers only have considerable effects on human resources practices for the acquired party. In this study, the redesign micro-merger had considerable effects on both disciplines.

Prior research (e.g. Napier, 1989) has indicated that the type of micro-merger has an effect on the planned level of integration in working procedures. The cases demonstrated that the mergers introduced new ways of working and new team structures, thus prompting the disciplines to cooperate more intensively and learn from each other. At least in the short run, extension mergers did not result in standardized working procedures and thus had less of an effect on governance and work routines within the newly merged entity. However, in long term, the disciplines are willing to work towards a standardized approach to the front office to improve patient services. This finding on long-term results contradicts Napier's (1989) conclusion that extension mergers are unlikely to trigger major changes. Within collaborative mergers, however, the new teams meant significant changes. That said, although Napier (1989) indicated otherwise, the micro-mergers did not lead to staff reductions, although some

staff members were replaced in all three cases. During the redesign merger, the acquiring discipline adopted the acquired discipline's procedures and the acquired discipline will have to adopt the acquired discipline's procedures. In contrast, in the collaborative mergers, previous working procedures were combined into a single new approach. These findings resulted in the follow proposition:

Proposition 7. The type of micro-merger influences the extent to which working processes are integrated and standardized.

Merging syndrome

Some studies have focused on the outcomes of mergers, concentrating on the reactions of stakeholders, and especially employees and managers (e.g., Ivancevich, et al. 1987; Marks & Mirvis, 2011; Napier, 1989; Sinkovics, et al., 2011). For example, Marks & Marvis (2011) and Ivancevich et al. (1987) understood mergers as stressful for employees, because they have little control over the situation, feel uncertain about the futures, and may face new positions and changing work relationships.

This study viewed merging syndrome as a moderating factor in the relationship between the type of micro-merger and its outcomes. In line with the previous literature on merging syndrome (e.g., Marks & Mirvis, 2011; Sinkovics, et al., 2011; Napier, 1989; Appelbaum & Gandell, 2003; Ivancevich, et al., 1987; Appelbaum, et al., 2000; Kilfoil & Groenewald, 2005), initial reactions to the micro-merging process included fear, insecurity, and anxiety. Ivancevich, et al. (1987) indicated that each merger entails its own set of events, responses, and outcomes.

In this study, the extension mergers led to less anxiety and stress, because there were no changes to team structures, policies, and working procedures. However, this was not the case for the collaborative mergers and the redesign merger. In line with Ivancevich, et al. (1987), in each case, the merger meant a transfer to a new location, new colleagues, and new managers. These factors, in turn, caused stress for employees. However, for the extension micro-mergers, changes regarding colleagues and managers were less significant than in the collaborative and redesign micro-mergers. In the case of the extension micro-mergers, managing the newly merged entity was a task rather than a function. During the collaborative merger, fewer feelings of fear, insecurity, and anxiety appeared, although some disciplines resisted formally moving to the new location. Although the mergers sought to encourage cooperation in delivering high-quality services, and all disciplines wanted to work at the new location, the changes in organizational power led the management to resist formally moving to the newly merged entity. This is in line with Ivancevich, et al. (1987), who suggested that changes in organizational power, status, and prestige can result in stress. The redesign merger led to more fear, anxiety, and insecurity, especially where the acquired discipline was concerned. In that case, the acquired discipline was much smaller than the acquiring discipline. This meant that the acquiring discipline first needed to learn the acquired discipline's policies and procedures in case its staff members was absent. However, that prompted the staff from the acquired discipline to fear job changes and job loss. Thus, in accordance with Ivancevich, et al. (1987), different types of micro-mergers lead to different sources of stress.

Regarding the types of micro-mergers and performance, the cases implied that the greater the stress, the lower the PSF's performance. Likewise, as stress levels fall, the PSF's performance increases. This result suggested that extension micro-mergers trigger a less severe merging syndrome, with performance remaining constant. Collaborative micro-mergers result in a moderate merging syndrome and enhanced performance. Finally, redesign micro-mergers mean a severe merging syndrome. In such cases, performance can initially decrease and then rise. This led to the following proposition:
Proposition 8. The severity of the merging syndrome depends on the type of micro-merger, and the more intense the merging syndrome, the lower the PSF's performance.

Equivalency

The M&A literature distinguishes between mergers of equals and acquisitions in which one party dominates the other. Multiple researchers have concluded that power differences play an important role in mergers, because the dominant organization is likely to influence the shape of the newly merged entity (Gleibs et al., 2010; van Knippenberg et al., 2002).

In this study, there were no power differences between the disciplines during the mergers, with all disciplines treated as equals within their new departments. Therefore, the results support Napier's (1989) conclusion that a relatively equal power relationships contributes to a willingness to build a new firm. Despite the considerable size differences between the disciplines comprising the new outpatient departments, they all worked together, and no discipline dominated the process. Thus, as compared to the previous literature (e.g., Gleibs et al., 2010), large departments were not more influential.

The early literature stressed that communication is the key to a successful merger (e.g., Angwin et al., 2014; McEvily, et al., 2003). Moreover, more recent literature has implied that merging syndrome (characterized by reduced communication between the management and employees) is the root cause of communication breakdowns (Appelbaum et al., 2000; Marks & Marvis, 1985). Therefore, communication can help to resolve uncertainty as quickly as possible (Appelbaum et al., 2000). Thus, in these cases, it was essential for UMCG to keep employees involved in, and informed about, the micro-merging process and to give them some authority over it. This helped to eliminate resistance to the micro-mergers. This is in line with Ivancevich, et al. (1987), who indicated that a lack of accurate information can lead to erroneous appraisals and high stress levels. Research has found that managers need to learn to cope with their employees' emotions to help reduce their sense of uncertainty (Appelbaum et al., 2000; Sinkovics, et al. (2011). Therefore, in line with Appelbaum et al. (2000), governance had a significant effect on the severity of the merging syndrome. Especially for the Surgery department, managers' ability to limit uncertainty and help their employees create a new social identity within the newly merged entity proved essential. That capability eventually led to service improvements.

To expand the literature on merging syndrome, in this paper, equivalency in power is seen as the key to success, because it makes communication easier at all levels easier, thus also enhancing trust. In the case study, equivalency in power was the key to cooperation, because it eased inter-disciplinary communication, thus strengthening trust. Kim and Park (2015) came to similar conclusions and found

that solid communication skills are critical for building trust between partners. In addition, McEvily, et al. (2003) indicated that trust has important effects in many areas, including communication and satisfaction at both the individual and unit levels. Therefore, there can be suggested that better communication and more trust result in a less severe merging syndrome. This led to the following proposition:

Proposition 9. Equivalency between disciplines generates higher levels of communication and trust, which leads to a less severe merging syndrome and thus moderates the relationship between the type of micro-merger and the PSF's performance.

Feelings of unity

Moreover, feelings of unity might also lead to a less severe merging syndrome. Therefore, both equivalency and feelings of unity have a positive influence on merging syndrome, as Figure 1 illustrates. The literature has described this from the social identity perspective, suggesting that individuals gain their sense of identity from the groups to which they perceive themselves as belonging (Kane, 2010). Since merging means a change to group membership (van Knippenberg et al., 2002), which can trigger feelings of uncertainty, the result can be a perceived threat to one's social identity (Sinkovics et al., 2011).

In the cases, the disciplines needed to cooperate in delivering professional services. At the very least, they needed to share a physical location. The results demonstrated that such cooperation enhanced the social identities of the individuals belonging to the new, multidisciplinary teams. Moreover, a specialized new entity creates an "us versus them" mindset, with members seeing themselves as distinct from the rest of the organization but equivalent to each other. This is in line with Tajfel and Turner's (1979) conclusion that people identify themselves with a group when they see it as positively distinct from others. Moreover, the results also conform with Ashforth and Mael's (1989) supposition that individuals derive their social identities not only from their organization but also from their work group, department, union, or lunch group.

In addition, the results demonstrated that as cooperative service delivery grows stronger, the more likely the surrounding environment is to recognize the department as a separate entity. This boots members' sense of identification with the newly merged entity. However, to the author's knowledge, the literature has not explored the phenomenon of external recognition in relation to social identity theory. In addition, the literature has not linked merging syndrome and social identity. However, studies on merging syndrome (e.g., Napier, 1989; Sinkovics, et al., 2011) have indicated that mergers can result in new teams. This can lead to uncertainty, thus triggering emotions and leading to perceived threats to one's social identity. Also, the literature on social identity has suggested that identifying with the pre-merger organization hinders the merging process and creates the potential for conflict, competition, and discrimination (Gleibs, et al., 2010). Therefore, this paper extends the literature on social identity and merging syndrome via the following proposal:

Proposition 10. Feelings of unity and, in particular, external recognition of this unity lead to enhanced social identity, resulting in a less severe merging syndrome. Thus, feelings of unity results in a less severe merging syndrome, which moderates the relationship between the type of micro-merger and the PSF's performance.

CONCLUSION

This study contributes to the literature on M&As by highlighting the concept of micro-mergers within PSFs. This paper extends the literature by indicating different types of micro-merging leading to a certain increase or decrease in performance of the PSF. In addition, this paper recognizes micro-mergers to lead to a new standardized way of working within the newly merged entity.

This paper's central research question asked: **How do different types of micro-mergers affect the performance of PSFs?** The results clearly indicate that extension micro-mergers neither lead to performance increases nor performance decreases. On the other hand, collaborative and redesign micro-mergers both boost PSF performance. However, redesign micro-mergers initially lead to a decline in performance. Moreover, merging syndrome moderates the relationship between the type of micro-merger and PSF performance. The more severe the merging syndrome, the lower the performance. Two factors have an effect on the extent of the merging syndrome: the equivalency between the disciplines and feelings of unity. Both result in a less severe merging syndrome.

Theoretical implications

This study can be of interest of scholars in the field of (micro-)mergers. It primarily contributes to literature on micro-mergers by exploring the micro-merging process within PSFs, and particularly the healthcare industry. Thus, it shed light on the relationship between different types of micro-mergers and their outcomes. While the existing literature has mainly focused on mergers with the healthcare industry overall, it has not examined mergers between healthcare providers, and so this study sought to fill that gap. Second, limited literature on micro-mergers exists. Therefore, this paper's insights on micro-mergers were derived from the literature on (domestic) M&As. In particular, this study investigated different types of micro-mergers using Napier's (1989) framework. In addition, this paper contributes to the field by examining micro-mergers' outcomes for customers. Within PSFs, performance does not simply mean making a profit. Rather, it is an issue of both survival and quality of life. Therefore, the outcomes of PSF mergers have enormous consequences for their customers.

Managerial implications

This study is also of interest of the management of (departments of) PSFs who seek to improve their performance by engaging in a micro-merger. The main implication of this study is that PSFs, to boost their performance, need to engage in a collaborative or redesign micro-merger. Regarding micro-mergers within PSFs, management needs to be aware of the different performance outcomes of different types of micro-merging. As such, only extending departments within the PSF with another department neither lead to an increase nor decrease in performance. Next, to achieve an increase in performance of PSFs, management should limit the severity of the merging syndrome. This can be done by creating equivalency in power between the merged departments and by generating feelings of unity within the newly merged department.

However, for PSFs, managing the micro-merging process in a proprietary way is difficult, because their main resources consist of individuals' tacit knowledge (Empson, 2001). Thus, governance has a significant effect on the micro-merging process. Management should communicate its motives for merging with employees to reduce uncertainty and resistance to the merging process. This communication should be clear and systematically organized. Everyone impacted by the merger should be involved in the merging process, so as to create high levels of trust. The management's ability to reduce uncertainty and stress in this way limits the severity of the merging syndrome. Regarding communication with employees, managers have a variety of options. These include organizing (in)formal meetings presenting the merging process and brochures. Furthermore, managers should be conscious that employees might perceive the merging process as a threat to their social identity. Therefore, it is important that both managers and employees learn to identify with the newly merged entity. Informal meetings allowing new colleagues to get to know each other are one means of achieving that goal. Furthermore, managers could also organize trainings to give employees more information about specific topics, thus motivating them and making them feel more like part of the team. Managers should be aware that employees can identify themselves within their new team and department, and that when the newly merged entity is recognized as a single group, social identification with that group will grow. Last, managers should take care that the dominant discipline does not become the influential discipline. Rather, there should be an appropriate balance between units.

Limitations

Although this study relied on a different level of analysis than that used by Napier (1989), applying her framework indicated the presence of different types of micro-mergers. Because this study examined three cases, different types of mergers were identified on the department and subgroup level. These micro-mergers were then compared to each other, regardless of the differences in levels. Second, the outcomes regarding PSF performance were based on the interviewee's subjective judgments. Performance was not measured in other ways, such as in terms of financial performance. Moreover, patients were not asked if they thought healthcare quality improved after the mergers.

The reader should bear in mind that the study is based on semi-structured interviews with managers who were involved in decision-making processes during the mergers within UMCG. However, only two MAAs of the merged outpatient departments were interviewed. Thus, although MAAs were a group within UMCG that were impacted by the micro-mergers, it was beyond the scope of this study to interview more MAAs. Additionally, only two physicians were interviewed. Interviewing more MAAs and physicians might have led to other insights on the micro-mergers within UMCG, in particular regarding the social identity.

Future research

This paper proposes a conceptual framework detailing the relationship between types of micro-mergers, their outcomes, and the factors moderating that relationship. Future research should further explore this relationship in a more quantitative matter, measuring PSF performance. Furthermore, future research should explore whether the results hold true for micro-mergers in other PSFs, or even in other industries.

PSF performance. Future research should examine PSF performance in connection with collaborative and redesign micro-mergers. This study demonstrated that redesign micro-mergers initially led to a drop in performance. In contrast, Napier (1989) stated that collaborative mergers can initially lead to declines in performance. Further research could explore whether collaborative mergers differ from collaborative micro-mergers in regard to this initial decrease in performance.

Redesign micro-mergers. Regarding the types of micro-mergers, future research is needed on redesign micro-mergers. According to Napier (1989), redesign mergers mean that the acquired firm adopts the policies and procedures of the acquiring firm. However, this study found that the acquiring discipline also learned the policies and procedures of the acquired discipline. Future research could explore whether this is the case in all kinds of redesign micro-mergers or whether Napier's (1989) framework should be extended to include additional, as-of-yet unidentified (micro-)mergers.

Extension micro-mergers. Last, future research should consider whether extension micro-mergers differ from "normal" extension mergers in terms of employees' willingness to work towards a standardized procedures. Although Napier (1989) stated that firms do not undertake extensions mergers out of a desire for change, this study found that in the long run, extension micro-mergers to seek to bring about changes, despite not initially intending to do so.

REFERENCES

Abrams, D., & Hogg, M. A. (1990). Social identity approach. *Social identity theory: Con*, 1-9.

Agarwal, S., Krishna Erramilli, M., & Dev, C. S. (2003). Market orientation and performance in service firms: role of innovation. *Journal of services marketing*, *17*(1), 68-82.

Angwin, D. N., Mellahi, K., Gomes, E., & Peter, E. (2014). How communication approaches impact mergers and acquisitions outcomes. *The International Journal of Human Resource Management*, 1-28.

Appelbaum, S. H., Gandell, J., Yortis, H., Proper, S., & Jobin, F. (2000). Anatomy of a merger: Behavior of organizational factors and processes throughout the pre- during- post-stages (Part 1). *Management Decision*, *38*(9), 649-661. doi:10.1108/00251740010357267

Appelbaum, S. H., & Gandell, J. (2003). A cross method analysis of the impact of culture and communications upon a health care merger: Prescriptions for human resources management. *Journal Of Management Development*, *22*(5), 370-409. doi:10.1108/02621710310474750

Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *Academy of management review*, *14*(1), 20-39.

Auchus, R. J., Feldman, Witche, S., Leight, K. R., Aisenberg, J., Azziz, R., Bachega, T. A., & Katz, A. L. (2010). Guidelines for the Development of Comprehensive Care Centers for Congenital Adrenal Hyperplasia: Guidance from the CARES Foundation Initiative. *International Journal Of Pediatric Endocrinology*, 1-17. doi:10.1155/2010/275213

Bazzoli, G. J., LoSasso, A., Arnould, R., & Shalowitz, M. (2002). Hospital reorganization and restructuring achieved through merger. *Health care management review*, *27*(1), 7-20.

Bello, D. C., Radulovich, L. P., Javalgi, R. R. G., Scherer, R. F., & Taylor, J. (2016). Performance of professional service firms from emerging markets: Role of innovative services and firm capabilities. *Journal of World Business*, *51*(3), 413-424.

Berry, L. L., & Bendapudi, N. (2007). Health care: A fertile field for service research. *Journal Of Service Research*, *10*(2), 111-122. doi:10.1177/1094670507306682

Caiazza, R., & Volpe, T. (2015). M&A process: A literature review and research agenda. *Business Process Management Journal*, *21*(1), 205-220.

Cartwright, S., & Cooper, C. L. (1993). The role of culture compatibility in successful organizational marriage. *Academy Of Management Executive*, *7*(2), 57-70. doi:10.5465/AME.1993.9411302324

D'Antone, S., & Santos, J. B. (2016). When purchasing professional services supports innovation. *Industrial Marketing Management*.

Damman, O. C., Hendriks, M., & Sixma, H. J. (2009). Towards more patient centred healthcare: A new Consumer Quality Index instrument to assess patients' experiences with breast care. *European Journal of Cancer*, *45*(9), 1569-1577.

Daniel, T. A. (1999). Between Trapezes: The Human Side of Making Mergers and Acquisitions Work. *Compensation & Benefits Management*, *15*(1), 19-37.

Devoge, S., & Shiraki, J. (2000). People factors: The missing link in merger success. *Compensation & Benefits Management*, *16*(1), 26.

Empson, L. (2000). Merging Professional Service Firms. *Business Strategy Review*, *11*(2), 39.

Empson, L. (2001). Fear of exploitation and fear of contamination: Impediments to knowledge transfer in mergers between professional service firms. *Human Relations*, *54*(7), 839-862.

Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of management review,* 14(4): 532-550.

Giessner, S. R., Ullrich, J., & van Dick, R. (2012). A social identity analysis of mergers & acquisitions. *Handbook of mergers & acquisitions*, 474-494.

Gijsenberg, M. J., van Heerde, H. J., & Verhoef, P. C. (2015). Losses Loom Longer Than Gains: Modeling the Impact of Service Crises on Perceived Service Quality over Time. *Journal Of Marketing Research (JMR)*, *52*(5), 642-656.

Gleibs, I. H., Noack, P., & Mummendey, A. (2010). We are still better than them: A longitudinal field study of ingroup favouritism during a merger. *European Journal Of Social Psychology*, *40*(5), 819-836.

Greenwood, R., Hinings, C. R., & Brown, J. (1994). Merging professional service firms. *Organization Science*, *5*(2), 239-257.

Gupta, S., & Zeithaml, V. (2006). Customer metrics and their impact on financial performance. *Marketing Science*, *25*(6), 718-739.

Haucap, J., & Stiebale, J. (2016). *How mergers affect innovation: Theory and evidence from the pharmaceutical industry* (No. 218). Heinrich-Heine-Universität Düsseldorf, Düsseldorf Institute for Competition Economics (DICE).

Hayford, T. B. (2012). The impact of hospital mergers on treatment intensity and health outcomes. *Health services research*, *47*(3pt1), 1008-1029.

Hinds, P. J., & Mortensen, M. (2005). Understanding Conflict in Geographically Distributed Teams: The Moderating Effects of Shared Identity, Shared Context, and Spontaneous Communication. *Organization Science*, *16*(3), 290-307. doi:10.1287/orsc.1050.0122

Hogg, M. A., & Terry, D. I. (2000). Social identity and self-categorization processes in organizational contexts. *Academy of management review*, *25*(1), 121-140.

Ivancevich, J. M., Schweiger, D. M., & Power, F. R. (1987). Strategies for Managing Human Resources During Mergers and Acquisitions. *Human Resource Planning*, *10*(1), 19-35.

Kane, A. A. (2010). Unlocking knowledge transfer potential: Knowledge demonstrability and superordinate social identity. *Organization Science*, *21*(3), 643-660.

Kilfoil, W.R. and Groenewald, T. (2005). Mergers and change management at the micro level: a case study, *SA Journal of Human Resource Management, 3*(2), 11-18.

Kim, B. K., & Park, S. K. (2015). The role of partner communication on cooperative R&D between SMEs and public research institutes in Korea. *Asian Journal of Technology Innovation*, *23*(3), 366-382.

Kraaij, T., Heinen, W., & de Blok, S. (2012). *Duurzame zorgspecialisatie als langetermijnstrategie voor ziekenhuizen*. Holland/Belgium management review. Retrieved from http://www.squarewise.com/downloads/publicaties/HMR_142_KraaijHeinenBlok_Zorgspecialisatie.pdf

Lawlor, J. (2013). Employee perspectives on the post-integration stage of a micro-merger. *Personnel review*, *42*(6), 704-723.

Lee, R. P., Ginn, G. O., & Naylor, G. (2009). The impact of network and environmental factors on service innovativeness. *Journal Of Services Marketing*, *23*(6), 397-406. doi:10.1108/08876040910988183

Marks, M. L., & Mirvis, P. H. (2001). Making mergers and acquisitions work: Strategic and psychological preparation. *The Academy of Management Executive*, *15*(2), 80-92.

Marks, M. L., & Mirvis, P. H. (2011). Merge ahead: A research agenda to increase merger and acquisition success. *Journal of business and psychology*, *26*(2), 161-168.

McEvily, B., Perrone, V., & Zaheer, A. (2003). Trust as an organizing principle. *Organization science*, *14*(1), 91-103.

Miles, M.B., Huberman, A.M. (1994), *Qualitative analysis: an expanded sourcebook*, 2nd edition. Sage: London.

Napier, N. K. (1989). Mergers and acquisitions, human resource issues and outcomes: A review and suggested typology. *Journal of management studies*, *26*(3), 271-290.

Noor, K. B. M. (2008). Case study: A strategic research methodology. *American journal of applied sciences*, *5*(11), 1602-1604.

Postma, J., & Roos, A. (2016). Why Healthcare Providers Merge. *Health Economics, Policy And Law*, *11*(2), 121-140.

Reihlen, M., & Apel, B. A. (2007). Internationalization of professional service firms as learning-a constructivist approach. *International Journal of Service Industry Management*, *18*(2), 140-151.

Ross, A. (2016). Establishing a system for innovation in a professional services firm. *Business Horizons*, *59*(2), 137-147.

Schmid, A., & Varkevisser, M. (2016). Hospital merger control in Germany, the Netherlands and England: Experiences and challenges. *Health Policy*, *120*(1), 16-25.

Sinkovics, R. R., Zagelmeyer, S., & Kusstatscher, V. (2011). Between merger and syndrome: The intermediary role of emotions in four cross-border M&As. *International Business Review*, *20*(1), 27-47.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. *The social psychology of intergroup relations*, *33*(47), 74.

Ullrich, J., Wieseke, J., & Dick, R. V. (2005). Continuity and change in mergers and acquisitions: A social identity case study of a German industrial merger. *Journal of Management Studies*, *42*(8), 1549-1569.

UNCTAD (2000). *World Investment Report 2000: Cross-Border Mergers and Acquisitions and Development*, UNCTAD, New York and Geneva.

van Aken, J., Berends, H., & Van der Bij, H. (2012). *Problem solving in organizations: A methodological handbook for business and management students*. Cambridge University Press.

van Dick, R., Ullrich, J., & Tissington, P. A. (2006). Working Under a Black Cloud: How to Sustain Organizational Identification after a Merger. *British Journal Of Management*, *17*S69-S79. doi:10.1111/j.1467-8551.2006.00479.x

van Knippenberg, D., van Knippenberg, B., Monden, L., & Lima, F. (2002). Organizational identification after a merger: A social identity perspective. *British Journal of Social Psychology*, *41*(2), 233-252.

Vogus, T. J., & McClelland, L. E. (2016). When the customer is the patient: Lessons from healthcare research on patient satisfaction and service quality ratings. *Human Resource Management Review*, *26*(1), 37-49. doi:10.1016/j.hrmr.2015.09.005

von Nordenflycht, A. (2010). What is a professional service firm? Toward a theory and taxonomy of knowledge-intensive firms. *Academy of management Review*, *35*(1), 155-174.

APPENDIX A: INTERVIEW QUESTIONS

Introduction

Introducing myself: Nadine Blouw, student of Strategic Innovation Management at the University of Groningen. Research for the UMCG Urology department. Micro-merging within UMCG: Merging several disciplines with new outpatient departments

Warming up: Thank you for participating.

Interview duration: Approximately one hour.

Transcribing the interviews: Ask for consent to record the interview.

Anonymity: Confidentiality is guaranteed.

General information

1. Could you briefly introduce your new outpatient department and describe the project?

The merging process

2. Could you describe the process of merging into your new outpatient department?
3. What did you do, as a manager, to make the merging process as smooth as possible?
4. Were there any changes regarding the governance of the outpatient department?
5. When you look back, what was the largest hurdle you faced during the merging process?
6. What do you see as a large hurdle that still remains to be tackled?
7. If you had to identify at least three issues that were important during the merging process, what would they be?

Merging syndrome

8. What were the management's initial reactions prior to the merging process?
9. What were the staff's initial reactions prior to the merging process?
10. What were the patients' initial reactions prior to the merging process?
11. How does everyone feel about the merging process at this moment?

Consequences of the merging process for UMCG

12. What have been the consequences of creating new outpatient departments within UMCG?
    a. What do you see as the most positive outcome of the merger?
    b. What do you see as the most negative outcome of the merger?
13. Could you tell me something about the outpatient department's working procedures?
    a. How are working procedures different within the new outpatient department as compared to prior the merging process?

Consequences of the merging process for patients

14. In your opinion, what have been the consequences of the merging process for patients?

Social identity

15. Are/were there differences between the parties in terms of size and power?
16. Has anything changed since the merging process in terms of team structure, reassignments, and redundancies?
    a. How did the management and the staff members handle this?
17. Has solid cooperation been established within the outpatient department?
18. In your opinion, does the outpatient department have a team feeling or an "us versus them" feeling?
19. Would you say that the outpatient department has become one team?

Quality of healthcare

20. Are you satisfied with the outpatient department?
21. In your opinion, has healthcare quality improved since the merging process?

Ending the interview

Thanking the respondent for his or her time and participation.