Valued Stakeholders or Unwanted Stepchildren?—A Stepfamily Theory Regarding Physician Group Divestitures

James J. Hoffman, Kimberly B. Boal, and David F. Robinson

Drawing upon stakeholder and stepfamily literature, this article identifies critical factors that determine physician group acquisition retention or divestiture. Based on the stepfamily literature propositions are developed regarding why many physician group acquisitions do not work.

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During the 1990s, health systems and physician practice management companies (PPMCs) across the U.S. competed with one another to buy physician practices and hire physicians as employees. An industry consulting firm found that publicly reported merger activity in medical groups rose sharply from 205 groups in 1995 to 265 groups in 1996, peaking in 1997 with 511 groups merging.[1] According to the Medical Group Management Association, many of these new partnerships have evolved into "distressed marriages" that may be heading towards divorce.[2] Not surprisingly the merger activity of medical groups has also dropped off sharply with 368 mergers in 1998 and only 135 in 1999.[1] In fact, according to industry observers, the same lawyers and consultants who enthusiastically worked to facilitate the acquisition process are now reported to be just as busy undoing many of these ill-fated mergers.[3]

Unfortunately, mergers and acquisitions of physician medical groups have received very limited attention from empirical researchers. In one of the few studies that examined this issue Burns, DeGraaf, and Singh[4] studied the effects of characteristics of markets, buyers and sellers, and their for-profit and not-for-profit status on acquisition of medical group practices. Using acquisition data from 1991–1995, the authors concluded that multispecialty groups were most likely to be acquired regardless of their profit/not-for-profit status. Their results also supported the idea that physicians were motivated to sell their groups based in part on the supply of physicians in the market as well as the degree of health maintenance organization (HMO) penetration and hospital vertical integration in the home market.[4] However, this research did not address postacquisition behaviors or divestiture of merged groups.

The fact that some of these physician group acquisitions are eventually divested is consistent with the more general business or corporate merger and acquisition literature. Mergers and acquisitions (M&As)

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James J. Hoffman, *College of Business Administration, Texas Tech University, Lubbock, Texas.*

Kimberly B. Boal, *College of Business Administration, Texas Tech University, Lubbock Texas.*

David F. Robinson, *College of Business Administration, Texas Tech University, Lubbock, Texas.*

have been studied since the early 1900s.[5] Although acquisitions are a popular means of diversifying, many are eventually divested.[6–8] Various researchers suggest that the rate of failure exceeds 50 percent.[6,9] Thus, the process of diversifying through acquisition is both a risky and expensive proposition. The costs associated with acquisitions and their divestiture leave managers wondering why some succeed and others fail. Even though research has begun to explain why firms undertake acquisitions,[10] the limited studies on the fate of specific acquisitions have focused primarily on efficiency and economic explanations.[6,8,9]

Prior research has suggested that firms are acquired and divested for efficiency and economic reasons.[10–13] In the health care industry the conventional wisdom has been that health care systems could strengthen market position by integrating, thereby consolidating hospitals, ancillary services, physician practices and other services, even health insurance, into large entities. In some cases, the purchases were one of the cornerstones of a proactive strategy to build integrated delivery systems and prepare for future risk-based contracting.[14] However, as mentioned above, in many cases previously acquired physician groups are being divested.

The relationship and integration of two firms as a determinant of the union's fate are still underexplored and leave many questions unanswered. Haspeslagh and Jemison[15] and Ramanujam and Varadarajan[16] have argued for the importance of studying the integration mode or process that organizations use if they are to achieve theoretical synergies promised by those pursuing organizational growth and renewal through mergers and acquisitions. Difficulties with postmerger integration are increasingly cited as the reason why the theoretical synergies organizations hope for, fail to materialize.[15,17]

There is an increasing body of anecdotal and empirical evidence that difficulties in integration of physicians from medical groups into acquiring hospitals and other health care organizations may in part lead to the breakup of the combined organizations.[3] Disagreement of physicians over the group's day-to-day management combined with falling income have caused a great deal of conflict in many medical groups. These group conflicts led to loss of physicians who preferred to return to smaller, more independent group practices even though the exiting physicians would face greater financial risk.[18] Dissatisfaction among physicians has led to experimentation with unionization by physicians. Fear of the consequences of owning unionized physician medical groups is likely to be an impetus to sell medical groups and avoid future management–union conflict.[19] There has also been difficulty in formerly independent physician-owners making the transition into larger organizations where they are treated as employees with employment contracts to fulfill.[20(pp.5–16)]

These observations indicate that many postmerger integration problems may stem from poor stakeholder management. For example in many medical group acquisitions, hospitals promised to help merged physicians with hiring, firing, billing and guaranteed salaries but many did not deliver on these promises.[3] Failure to follow through on their commitments is consistent with Blair, Payne, Rotarius, Whitehead, and Whyte,[21] who concluded that few health care organizations have a fully developed strategic approach for managing their key stakeholder relationships.

Stakeholder theory suggests that managers should strive to create and maintain mutually trusting and cooperative relationships with corporate stakeholders, the theory being that firms whose managers establish and maintain mutually trusting and cooperative relationships with their stakeholders will achieve competitive advantage over those whose managers do not.[22] The essential premises of stakeholder theory are as follows:

1. The corporation has relationships with many constituent groups ("stakeholders") that affect and are affected by its decisions;[23]
2. The theory is concerned with the nature of these relationships in terms of both processes and outcomes for the firm and its stakeholders;
3. The interests of all (legitimate stakeholders) have intrinsic value, and no set of interests is assumed to dominate the others;[24,25] and
4. The theory focuses on managerial decision making.[25]

Unfortunately, it may be difficult for parent health care firms to establish mutually trusting and cooperative stakeholder relationships with physicians from acquired groups due to many of the same reasons that stepfamilies do not always have trusting and cooperative relationships among family members. This article uses the stepfamily literature as a basis for developing a new theory of physician group retention and divestiture. Specifically, four propositions are put forth regarding factors that lead to the failure of physician group acquisitions. Steps that can be taken to make acquired physicians feel less like unwanted stepchildren and more like valued members of the acquiring health care organization are then discussed.

A STEPFAMILY THEORY

Boal, Michael, and Farias[26] argue that stepfamilies and merged organizations face many of the same difficulties (e.g., high rates of failure, coping with loss and change, unrealistic beliefs, life-cycle discrepancies, power issues, insiders versus outsiders, loyalty conflicts, and boundary problems). They also argue that stepfamilies and merged organizations face many of the same tasks (such as establishing new relationships and creating new coalitions, forming new traditions, dealing with losses and changes, and negotiating different developmental needs). In addition stepfamilies and merged organizations share many of the same characteristics (e.g., complex structures, high stress levels, no shared history, role ambiguity, and cultural shock). Thus, in many ways, stepfamilies bear a striking resemblance to health care organizations that have merged with (or acquired) physician groups. Under this scenario the health care organization and the physician group organization would be equivalent to a newly married couple. Similarly, just as a stepchild is characterized as not having a biological link to both parents in the home, physicians from the group would be equivalent to stepchildren in a newly formed family.

The ultimate fate of the stepfamily relationship is influenced by many factors involving stepparents and stepchildren.[27] An important stream in the stepfamily literature has focused on the causes of stepfamily stability and disruption.[28–30] Although stepfamilies have more stress and lower cohesiveness than nuclear families,[31,32] marital satisfaction and happiness is not significantly different between them.[30,33] In spite of this, stepfamilies are more susceptible to disruption and failure.[30,34] Stepparents have high levels of conflict over stepchildren,[35] and stepchildren are the primary destabilizing element of the relationship.[36]

Why are stepfamilies more susceptible to disruption than nuclear families? The *biological-discrimination* approach proposes that for stepfamilies the emotional and motivational component of parenting are absent between the stepparent and stepchild.[37] This absence results in less positive interaction and increases the likelihood of neglect and abuse of stepchildren.[38,39] Stepparents also typically favor their own children over stepchildren.[40] The *incomplete-institution* approach suggests that stepfamilies are under greater stress than nuclear families because both parents and children lack clear guidelines of role definition for appropriate behavior and procedures for dealing with problems.[36] Using these themes, four propositions are developed regarding factors that lead to physician group acquisition failure. The four propositions are based on the heterogamy, economic distress, remarriage market, and commitment perspectives.

PROPOSITIONS

Heterogamy

Heterogamy, or dissimilarity, has been depicted as a potential source of conflict, value dissonance, and power imbalance that can induce instability in a family relationship.[30,41,42] In a stepfamily situation, the initial characteristics of the joining families can play an important role in creating harmony or conflict in the relationship. Differences in family type (i.e., where family type is based on general background factors such as age, education level, religion, and goals) and family size can result in value discord or generate imbalances of power between the members of the "new" family. These differences heighten the instability of the relationship and increase its disruption rate.[29,42]

Similar to stepfamilies, the initial characteristics of the two organizations involved in an acquisition can play a critical role in the relationship that is established between the two organizations and whether the union remains intact. Research has suggested that the more similar the two firms, the greater the organizational fit, and thus the more likely they will stay together. Research also suggests the more heterogamous, the greater the chance of dissolution.[15,43–47] Specifically, research has suggested that sources of heterogamy can arise from: industry and product market differences;[43] differences in human resources;[44] organizational structure;[45] managerial style and incompatibilities;[46] and organizational culture.[15,47] In the section below, we focus our discussion on two characteristics: organizational type and size. We focus on organization type and size because they are often correlated with differences in various organizational systems and industry membership.

Organization Type

Stepfamilies arise because of remarriages by one or both partners in which one or both parties bring children to the marriage. For example, a common pathway to remarriage is first marriage-divorce-remarriage. In general, most remarriages follow at

least one divorce, though there are exceptions involving death of a previous spouse or separation where one of the parents with children was never previously married. In some cases one or both of the partners have been involved in serial remarriages and may bring children to the new marriage from more than one previous marriage. Ganong and Coleman[48] suggest that if only the issues of where children reside and which adult is genetically (or legally) related to which child, then there are as many as 30 structural forms of stepfamilies.

Like stepfamilies there are also many different types of health care organizations that operate in today's turbulent health care environment (i.e., insurance companies, hospitals, physician groups). Depending on what type of business the acquiring health care firm is in, an acquisition of a physician group can be a horizontal acquisition (i.e., a physician group acquires another physician group) or a vertical acquisition (i.e., a hospital or an insurance company acquires a physician group). The type of acquisition that is done (i.e., horizontal or vertical) is another potential source of heterogamy and disharmony.

Firms in the same type of business (i.e., another physician group) often share similar markets, cognitive maps regarding industry factors, and strategies, and the union of same-type firms is expected to result in strategic fits and higher performance.[43,49] The strategic fits that are anticipated from same-type firm acquisitions should result in greater market power, economies of scale, or economies of scope.[50] The realization of these strategic fits is expected to keep the marriage between the acquiring health care organization and the acquired physician group together.

Acquiring health care firms that are not physician groups (i.e., hospitals or insurance companies) may differ on key characteristics and do not bring such strategic fits to the acquiring health care firm. Acquisitions of dissimilar types of organizations, however, can provide complementary assets and resources that enhance learning capabilities and know how as well as providing coinsurance against market fluctuations.[50–52] The inconsistent findings with respect to relatedness and performance,[15] however, suggest that the value to be derived from any acquisition depends upon the skill with which problems of integration are handled.[53] Heterogamy makes this process more difficult, but not impossible. For stepfamilies, members that differ regarding race, religions, education, or other demographic characteristics[29] are more apt to have conflict regarding values, goals, or even role definition. This heterogamy results in a higher incident of relationship disruption.[30] Similarly, organizations managing different types of businesses (such as not-for-profit and for-profit) can lead to conflicts and differences in the focus, vision, and values of the organization, its employees and managers. These conflicting values and foci can result in disruptions of the interorganizational relationship. In the case of a physician group being acquired by a nonphysician group (such as a hospital or health maintenance organizations), we predict the following:

> Proposition 1A: Acquisitions of physician groups by nonphysician groups (i.e., hospitals or insurance companies) are more likely to result in the divestiture of the physician group whereas acquisitions of physician groups by other physician groups are more likely to result in the retention of the acquired physician group.

Size

Heterogamy in size may result in a source of power imbalance and conflict between the acquiring health care firm and the acquired physician group. On the acquisition side, Burns, DeGraaf, and Singh[4] found that larger medical groups were more likely to be acquired. However, what may be key to actual postacquisition integration is the *relative* size of the physician group when compared to the acquiring health care firm. Larger acquiring firms should have greater power over the physician group with regard to managerial decisions, resource allocation, and inertia.[54] Large firms, especially ones that are geographically dispersed, such as a 20-hospital integrated delivery

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system, are more likely to rely on impersonal bureaucratic mechanisms of control.[55] While these bureaucratic mechanisms may be accepted and well understood in the parent firm, they may seem very complex and impersonal to a small physician group.

Stepfamily research indicates that ambiguities in parent and child roles and use of coercion in family processes are sources of concern for stepfamilies. For example, stepchildren reject stepparents who take on a disciplinary role (i.e., use power) early in their relationship.[56] Remarried individuals tend to view their new families as more stressful and less cohesive than first-marriage individuals.[57] In stepfamilies, role ambiguity stems from the renegotiation of relationships among all the members of the new stepfamily in addition to the existing relationships of the original families. Merging families of dissimilar sizes, where one parent has a number of children, and the other may not, creates a complex set of ill-defined relationships. Stepfamily members often do not agree on the role a stepparent should play in the family.[58] Research has also shown that role ambiguity faced by stepparents related to the formation of new relationships between stepfamily members leads to lower levels of stepparent satisfaction in the marriage, a potential precursor to marriage dissolution.[59]

Kusewitt[60] recommends that size differences between merging organizations should not be great. In merged health care firms, the use of bureaucratic rules, rather than personal interaction and professional norms, coupled with a size-based power differential could result in a sense of insecurity and uncertainty on the part of the acquired physician group. Similarity in firm size may reduce the potential for dissatisfaction because personnel would see more similarities in the operational issues facing the two organizations. Mutual understanding and decreased role ambiguity may result due to more negotiation and adjustment between organizations of similar size. A physician group's smaller relative size may also be easier, emotionally or financially, to be divested if the relationship is not working out or meeting the strategic objectives of the parent firm. Bergh[61] found that the smaller the size of the unit, relative to the acquiring health care firm, the more likely the unit would be divested.

Proposition 1B: The greater the relative difference in size between the acquiring health care firm and the physician group the more likely the physician group will be divested; the smaller this difference, the more likely the physician group will be retained.

Economic Distress

Just as the demographic differences between two merging families can influence the fate of the relationship, economic distress on either side of the two merging families as they enter the relationship can also be an important predictor of the success or failure of the union. Because economic distress has been related to the likelihood of disruption and dissolution in the human family,[62] the same can be expected for acquisition targets in the corporate family. Although acquisitions may be pursued to gain competencies, secure technology, fill out the business portfolio, or even as just a good turnaround opportunity, the acquisition of physician groups that have financial dysfunctions can increase the stress on the acquiring health care firm. Acquisitions that are more financially sound will not bring these problems into the relationship and should have more successful relationships. This leads to the following proposition:

Proposition 2a: The less financially sound the target physician group is, the more likely it will be divested; the more financially sound the acquired physician group is, the more likely it will be retained.

Economic distress may also result when the acquirer overextends its economic reach in the acquisition. This could occur when a firms borrows a significant amount of capital to finance an acquisition, but whose subsequent cash flow of the combined firm is inadequate to service the debt. While firms often seek market power[10] and new business opportunities,[12] efficiency losses and unrealized gains from over diversification eventually lead to divestment.[63–65]

Proposition 2b: The less financially sound the acquiring physician group is, the more likely the target group will be divested. The more financially sound the acquirer, the more likely the target will be retained.

Remarriage Market

The market for marriage, divorce, and remarriage (resulting in stepfamilies) increased dramatically as the U.S. shifted from an agrarian society to an industrial society. For example, divorce rates have skyrocketed from less than 10 percent in the late 1800s to around 50 percent in recent decades.[66] Nearly 80 percent of divorced persons find new partners and remarry, with half of these marriages also ending in failure.[67,68] The result of this has been that 60 percent of remarriages involve the custody of a child, thereby

creating a stepfamily.[67] In fact, recent estimates indicate that a 17-year-old child (born in 1980) has less than a 50 percent chance of living with both biological parents.[69,70] Overall, one third of all children are expected to become stepchildren by the time they are 18 years old. The numbers indicate that the institution of marriage itself is not the problem, but rather the choice of partners.[30]

Unstable marriages and related search behavior for a suitable new partner have been suggested to originate due to a partner comparing its situation (marital bargain) with other potential external marital bargains.[30] Also, economic motives may explain some degree of marriage instability. According to Becker, Landes, and Michael[41(p.1143)], "The optimal marital decision at any moment would be the one that maximizes the expected value of full wealth over the remainder of life, given the realizations up to that moment." However, relationship disruption is not an attractive option unless marital alternatives exist. In fact, in some instances the very existence of alternative partners predicted the disruption of the union, independent of satisfaction in the relationship.[41]

If an individual is seeking to maximize wealth or satisfaction through a different relationship, the possibility to find a match would be a function of the market–who is available, who is seeking this type of relationship, and how attractive they are to those seeking a new relationship. Whereas stepchildren, or subsidiaries, typically don't have the option to divorce or abandon the relationship, the market conditions for divestitures and acquisitions should influence whether or not divestiture is an attractive option. Throughout the 1990s there was a wave of M&A activity in the health care industry.[71] Some observers now, however, argue that the decade-long trend toward large-scale health care integration has turned into a wave of disintegration.[20(pp.17–38)]

This implication of an active M&A market is that the likelihood of any particular merger or divestiture occurring is a combination of the needs and resources of an acquiring health care firm and the availability of attractive potential partners (an active M&A market). As with the remarriage market, a health care firm may consider divesting a physician group for various reasons: The physician group may not be meeting the objectives that were desired,[72] may have poor financial performance,[73] or may produce greater financial gains for the acquiring firm if the physician group were sold off.[74] Regardless of the reason, the existence of an active health care industry M&A market will facilitate such a divestiture. If there are no active buyers seeking physician groups, it will be less attractive for sellers to divest their physician groups.

> Proposition 3: If an active market exists for similar acquisitions, the acquired physician group is more likely to be divested; the absence of such a market will result in the retention of the acquired physician group.

Commitment

As mentioned above, the social norms and current laws have made discontinuing a marital relationship more acceptable and easier to do than previously. Because the marriage relationship is no longer viewed as permanent by many, people may be more prone to ending the relationship when times get tough or when personal goals or needs change. With these issues in consideration, the level of commitment that an individual makes to the success of a relationship should play an important role in whether it thrives or fails.

Johnson[75] developed a framework that considers commitment to the marriage relationship at three levels: Personal, moral, and structural. *Personal commitment* stems from the desire to want the relationship to succeed and continue.[76] This commitment comes from the attraction to the relationship, attraction to the partner, and identification with the relationship. *Moral commitment* is based on the feeling that one ought to continue the relationship. The value of consistency, an individual's relationship-type values, and person-specific obligation to others can result in commitment based on a sense of moral obligation. *Structural commitment* is founded on constraining factors on the fate of the relationship. These factors may include social reaction, procedures for termination, irretrievable investments, and the lack of attractive alternatives. Based on the source and level of commitment, once a course of action is started, social and economic processes are employed that may be costly to terminate that course of action, regardless of whether the continuation of the relationship is desired or not.[77]

Similar to the commitment towards the union created as a stepfamily, health care organizations may enter a relationship with varying levels of commitment towards the success of that relationship. Even though the commitment toward the relationship could be manifest at the personal or moral levels, health care organizations typically deal with acquisitions at the structural level of commitment, with the relevant accompanying strategic and financial implications. Based on the remarriage market proposition,

the lack of attractive alternatives should decrease the likelihood of divestment. The difficulty and cost of terminating the relationship can also act as a deterrent for divestiture.[78] Regarding the acquisition of a physician group, the initial level of financial commitment, in terms of the value of the transaction, should be an important indicator of commitment to the acquisition and the relationship. The greater the financial commitment, or investment, the more likely the relationship will succeed and the acquired physician group will be retained. The lower the commitment, the greater the chance the relationship will fail.

Proposition 4: The lower the financial commitment made in the physician group acquisition, the greater the likelihood the physician group will be divested; the greater the financial commitment, the greater the likelihood the physician group will be retained.

MAKING PHYSICIANS FEEL LIKE VALUED STAKEHOLDERS

Presented above are four propositions regarding factors that lead to the failure of physician group acquisitions. Although not all situations lend themselves to physician group acquisitions being successful, there are still steps that can be taken to increase the chances of success. These steps have their roots in stepfamily theory and stakeholder theory and revolve around the establishment and maintenance of a healthy relationship between physicians and the acquiring organization.

Stakeholder theory suggests that it is equally important to consider both relationships and substance when negotiating strategically.[79] Similarly, stepfamily theory suggests that in order to establish and maintain a healthy relationship in a stepfamily, two important relationships must be managed simultaneously. The first relationship is between the parents. This is similar to the business-to-business relationship. The second relationship is between the stepparent and the stepchild. This is the organization to employee relationship. Stability and satisfaction in stepfamilies are based on developing a strong couple bond.[40,67] However, developing a strong couple bond, while developing relationships concurrently with stepchildren makes the process of couple bonding different in remarriages than first marriages. Stepfamily theory suggests that often so much effort is spent developing the parent-to-parent relationship that little energy is left to developing the parent-to-stepchild relationship. Furthermore, both stepparent and stepchildren lack mental models to guide them in establishing these new relationships.[48] One reason why stepparents fail is that they do little to prepare themselves for the challenges of stepparenting. Thus, a key is to develop mental models for both the parent-to-parent relationship as well as the new parent-to-stepchild relationship.

An important step in developing these mental models within the context of physician group acquisition is for the acquiring organization to work with physicians to set organizational goals and objectives. In this context, goals are considered to be broad directions that an organization wishes to pursue or results it hopes to accomplish within its mission. The primary goal of health care organizations is usually twofold in that the organization strives to fulfill its predetermined role in society (which in many cases involves providing the highest level of service possible to its patients) while still trying to remain fiscally strong. Unfortunately, these two goals are usually in direct conflict since the cost of providing services usually goes up as the level of service increases. While the mutual accomplishment of these two goals may be possible to a point, the long-term accomplishment is virtually impossible without the input and support of the acquired physicians.

It is also critical when setting the merged firm's goals and objectives to make sure that the acquired physician's goals and incentives are aligned with the parent health care firm's goals. In order to do this, incentives must be created for all components of the system to accomplish what is in the best interest of the system as a whole. When setting goals for the merged firm, physicians from both organizations as well as their health care executives must agree on: the goals for incentives, pitfalls to avoid, and an incentive system that integrates health plans, physicians, and hospitals.

Another step to establishing and maintaining a healthy relationship between physicians and the acquiring organization revolves around communication. Evolutionary scholars argue that stepparents invest less of themselves in their stepchildren because they are not genetically related.[80,81] This theory suggests that stepparents discriminate in favor of their own children.[82] Parents are perceived to be more supportive of children than are stepparents.[83] Efforts to improve communication between stepchildren and stepparents have been suggested to counter these perceptions. Stepparents are interpreters within stepfamilies, explaining their children to their spouses and vice versa. They do this to educate one about the other

so as to achieve a shared understanding.[84] This establishment of a shared understanding, a "thick middleground," is the most important task early on in the relationship. Failure to do this results in failure.[40]

One way to improve communication between physicians and the acquiring organization is to give the acquired physicians representation on the combined firm's board of directors and to include them on strategic management task forces. This should facilitate the development of a common vision among the physicians, health care executives, and members of the board of directors regarding the mission of the combined firm.

Another way to improve communication is to solicit input from physicians regarding the organization's present situation. In fact, acquired physicians can play a unique role in the newly merged health care firm by providing an outsider's perspective on the strengths, weaknesses, internal capabilities, and external environment. This new outlook may provide additional insights that enable the new firm to cope with rapid changes in the environment and possible unforeseen effects of prior decisions.

A third step to aid in the establishment and maintenance of a healthy relationship between physicians and the acquiring organization deals with conflict management. The stepfamily literature suggests that conflicts in remarriage generally center on issues related to children.[67,85] Conflicts arise over rules, disciplines, and resource allocation.[85] The presence of stepchildren increases the stress associated with role ambiguity and role strain related to the stepparent roles, and this in turn results in lower satisfaction with the new relationship.

Stepchildren face similar tasks in maintaining, renegotiating, and restructuring roles with parents, stepparents, extended stepkin and possibly stepsiblings.[84] This is made more difficult because both stepparents and stepchildren often begin relationships with unrealistically high expectations.

With regard to the acquisition of physician groups, one way to reduce the potential for conflict is for the combined firm to solicit physician input regarding what policies and procedures the combined health care firm should follow. In this context policies are considered to be broad guidelines for making decisions. Procedures are considered to be a system of sequential or concurrent steps essential to ensure that policies are carried out. Without physician input from both organizations, there is a high probability that policy and procedures may not be followed or worse yet that bad policies and procedures go undetected and are followed until something disastrous happens. Given the increased emphasis on avoidance of medical errors, the newly combined physicians and their supporting personnel must be integrated smoothly into the procedures that will be used by all physicians. Contributing to the complexity of integrating these two "families" may be: conflicts over the retention and integration of staff from the newly acquired practice, how appointments and operating rooms are scheduled, standard treatments for particular medical conditions, physician coverage for emergencies, and vacations and many other procedural issues.

The stepfamily literature also suggests that the new stepparent-to-stepparent relationship often results in loyalty conflicts as well as a loss of status and power for stepchildren. This can result in stepchildren becoming invested in seeing the remarriage fail. Over time, physicians will have developed strong loyalties to their employees and deep knowledge in the routines they use to treat patients. If the parent firm favors one group's practices and employees over the other, there is great potential for jealousy and dysfunctional behavior by physicians that will damage the new organization. Consequently, just as stepparents can be faced with the difficulty of developing a new couple bond in the presence of jealous children (who want the remarriage to fail), the new firm must strive to minimize these jealousies by building trust and showing evenhandedness in its retention and practice decisions.

Within the context of physician group acquisitions, the combined organization can reduce the likelihood of physicians becoming invested in seeing the merged organization fail by identifying and/or developing physician leaders and including them in all aspects of the decision-making process. This is critical since deci-

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sion making can be very difficult in health care firms due to the sometimes conflicting goals of maintaining both the patients' health and an economically healthy organization. With input and support from physician leaders during the decision making process, the combined health care firm can increase its chances of striking an effective balance among these sometimes conflicting decision criteria. Physician involvement in the decision process and supportive physician leaders can go a long way to motivate personnel to effectively implement the decisions of the new firm.

By applying these key points from stepfamily theory and stakeholder theory, merged organizations may be able to foster respect and cooperation among their key constituents. For example, in a collaborative mode, one health care organization helped its physicians, along with private practice physicians, form an independent physicians association (IPA). The parent organization provided the IPA with management support, helping the association negotiate discounts in insurance and supplies. The parent also helped facilitate easier access by its physicians to laboratory results, patient records, and data via the Internet.[3] While starting an IPA is not a solution to all problems, it does illustrate how a parent organization can create a cooperative atmosphere by trusting physicians with increased independence and building an improved organization that offers better business practices, leaving the physicians more time to practice medicine effectively. It is with cooperation between a parent organization and its medical group (i.e., "stepchildren") that merged organizations can create a positive atmosphere in which they can all reap the benefits of combining their strengths in a merged organization.

CONCLUSIONS

The purpose of this article has been to provide an alternative explanation for why physician group acquisitions fail and to offer steps that can be taken to increase their chances of succeeding. Whereas the current health care literature has dealt with acquisitions and divestitures as part of a diversification strategy, limited research has attempted to directly determine why certain acquisitions are retained or divested. Although this article doesn't completely resolve all of the issues surrounding the divestment of physician groups, it does furnish a broader perspective from where we can analyze the problem. It also establishes a new theoretical foundation from which physician group acquisition and divestiture activity should be studied.

At the level of practice, many health care executives have personal experience with coping with problems associated with stepfamily integration. Thus, stepfamily theory, even as metaphor, gives health care executives a new cognitive map for anticipating and coping with problems of physician group M&A integration. As this article has highlighted, there are many aspects that are similar between stepfamilies and corporate families involved in acquisitions. Not only are the general characteristics of these type of families comparable, but so are the dynamics and pressures that exist in them. Heterogamy among the stepfamily members, effectively dealing with preexisting family problems, and the level of commitment to the relationship all impact the fate of the union. This article only begins to tap the value of the stepfamily literature in explaining the acquisition and divestiture activities of health care organizations. Further utilization of this theory should continue to enhance our understanding of this phenomenon and may clear up some of the confusion that currently exists.

Overall, it is hoped that our application of stepfamily theory to the acquisition and divestiture activities of health care organizations will serve as a foundation for future research pertaining to the retention and divestiture of physician groups. It is also hoped that the steps identified above will provide health care executives with additional insight regarding how to make physicians of acquired medical groups feel more like valued stakeholders as opposed to unwanted stepchildren.

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