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AGREEMENT BETWEEN TOP MANAGEMENT TEAMS AND EXPECTATIONS FOR POST ACQUISITION PERFORMANCE

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This paper addresses theoretical gaps in the relationships among decision maker agreement, social context, and performance. Agreement is considered a multidimensional construct that is embedded in a social context of intergroup relationships. Four dimensions of agreement are specified: (1) perceived agreement, (2) actual agreement, (3) accuracy, and (4) agreement with one's own organization. Understood this way, agreement is associated with success expectations. Empirical tests of hypotheses derived from this view are based on data concerning agreement on acquisition goals by the top management teams from two hospitals in the year following an acquisition. Results support a multidimensional view of agreement, the importance of the intergroup context, and the association of agreement and expectations for success.

How decision makers agree or disagree on strategic issues is an important topic for students of organizations. Several studies have examined how agreement among managers develops and affects a firm. These results often suggest that agreement is positively related to performance.[1] Dess and Origer (1987) and Priem (1990), in reviewing the related idea of consensus, note theoretical gaps in the relationships among agreement, decision quality, and performance. These imply that agreement is inadequately specified as a construct in strategy research.

The point of this paper is twofold. First, agreement is viewed as a multidimensional construct that is embeddd in a social context of intergroup relationships. Second, agreement is shown to be associated with judgements of performance, although not in a uniform way across its different dimensions. Three dimensions are specified: (1) perceived agreement, (2) actual agreement, and (3) accuracy. The intergroup context of agreement is examined because agreement is seen as a multilevel phenomenon that encompasses individuals' judgements about their own situation, the comparison of such judgements with those of reference group members, and the projection of such judgements across formal and informal group boundaries.

Key words: Agreement, acquisitions, intergroup, implementation, hospitals

[1] Different studies use different terms for agreement. 'Agreement' is used here as a global term concerning the degree of similarity of positions held by different parties. As used here, it includes such more specific terms as consensus, which refers to a state of general agreement in the positions taken by all or most of a set of parties (Priem, 1990).

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In this study, acquisition integration provides the context for studying agreement because the groups and boundaries involved are clear and the issues for which agreeement is most important are readily identifiable. We study agreement over objectives among members of acquired and acquiring management teams in the year following a hospital combination. The salient area of agreement here is between two formerly distinct groups of managers. The decision context is thus an intergroup relation. Performance is assessed in terms of expectations for success.

Dimensions of agreement

Two dimensions of decision maker agreement are seldom separated in strategy research. *Perceived agreement* is the extent to which actors believe themselves to agree, while *actual agreement* is the real concordance of their positions. Prior studies have emphasized actual agreement, as measured by the variation of responses on items of interest (Dess, 1987). This does not indicate whether individuals perceive the level of agreement that actually exists, which is important if people act on their perceptions. Comparing perceived and actual agreement implies a third dimension, *accuracy*.

These dimensions allow a better specification of the relationships between agreement and performance. As shown in Figure 1, if perceived and actual agreement are high, performance benefits from cooperation. This reflects a frequently found positive association of agreement and performance (Bourgeois, 1980). If perceived and actual agreement are low, dysfunctional conflict may occur from the interaction of parties that do not agree on major objectives. The results of an undertaking between disagreeing parties need not suffer, however, if cooperation in the area for which there is disagreement is not necessary for the overall success of the undertaking.

Distinguishing perceived and actual agreement indicates that problems are likely with the off-diagonal cells of Figure 1—i.e. with situations in which perceived and actual agreement differ. When perceived agreement is high and actual agreement low, performance suffers from disillusionment and latest conflict, as parties who believe themselves to be pursuing the same objectives discover during the course of their

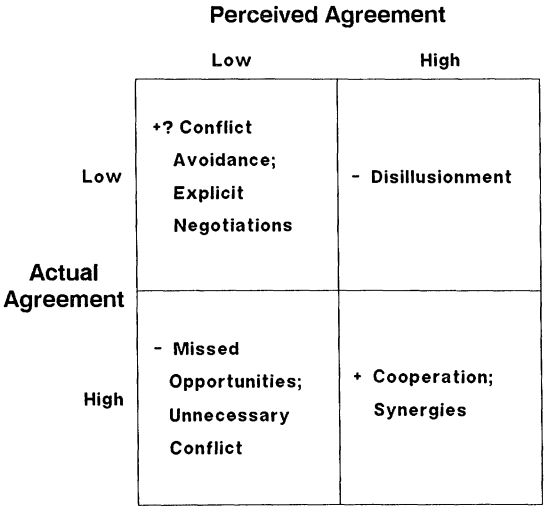

Figure 1. Performance consequences of differences between perceived and actual agreement.

interactions that they are not. On the other hand, if perceived agreement is low and actual agreement is high, performance suffers from missed opportunities and false conflict, as expectations of conflict become self-fulfilling (Brown, 1983; Hoch, 1987).

Multiple dimensions of agreement require multiple theories to understand them. Actual agreement may be largely explainable by the interests of individual actors. If one actor values an activity and another does not, one needs only self-interest to explain it. 'Rational' models of decisions, from unitary action to politics and coalition building (Allison, 1971), are examples of this. If perceived and actual agreement differ, affective and cognitive factors are needed to account for biases and differing expectations, while group and intergroup factors can account for collective distortions.

Along with the *content* of decisions, which can be considered in terms of individual interests, individual and group behavioral factors influence agreement, raising the theoretical problem of multiple levels of analysis. First, *individual* skills and biases will influence the levels of agreement reached by management (Duhaime and Schwenk, 1985). Second, *group* dynamics within the management team, such as conflict or cohesion, will influence agreement, by establishing the psychological context of individual judgements of agreement (Bateman and Zeithaml, 1989; Priem, 1990). Third, since executives are mem-

bers of the management team and representatives of their organizational functions and/or professional groups, *intergroup* factors will also influence agreement (Lawrence and Lorsch, 1967; Alderfer, 1977).

Our agreement variables address multiple levels of analysis. Perceived agreement is largely an individual judgement about the similarity of one's position with that of another. In contrast, actual agreement and accuracy combine an individual judgement with the real position of some group, thus including both individual and group levels of analysis. Whether agreement involves intergroup or just group relations depends on which groups are of interest, those to which the individual belongs or those to which the individual is an outsider.

Agreement and acquisition integration

Acquisition integration provides a focused context in which to study the ideas of agreement discussed above. Acquisitions are strategic decisions (Salter and Weinhold, 1979). Research suggests that clear rationales for acquisition, while necessary, are not sufficient for high performance. Sound management processes and implementation activities are also necessary (Hunt, 1990). Integration activities are often characterized by conflict (Marks and Mirvis, 1985) and poor performance (Scherer, 1986).[2] While studies of integration vary in topics and research designs, they share four themes that concern agreement: synergies, high stakes, complexity, and stress.

Synergies

'Synergies' refers to the multiplicative and additive benefits of acquisitions (Salter and Weinhold, 1979). Studies of acquisitions have emphasized an efficiency orientation with synergy arguments (Trautwein, 1990). Depending on one's goals, integration requires varying degrees of collaboration across formerly distinct organizational boundaries. The more value one expects, the more collaboration is needed (Singh and Montgomery, 1987). Agreement is needed where major synergies are expected and where the acquirer requires cooperation from the acquired firm (Souder and Chakrabarti, 1984).

High stakes

Failure is costly for acquirers and acquirees. The identity of the firm and security of employees are at risk for acquirees (Marks, 1981), while acquirers face lost premiums, reduced reputations, and takeover (Davidson, 1987). Such stakes make negotiated agreements desirable, but also increase the potential for conflicts and mistrust. High stakes place a premium on accurate judgements. How high a premium is an empirical question, although it is likely that as the amount of resources involved in a combination increases, so will the cost of errors in judgement. As Jemison and Sitkin (1986) suggest, parties could reach an agreement in principle regarding an acquisition and leave the details to implementation. While this would alleviate the need to reach agreement on all matters, it would also increase the need for accuracy on the agreement judgements that are made.

Complexity

A problem related to that of high stakes is complexity. Acquisitions are complex undertakings in which available information is often incomplete and distorted. Synergies are easily overestimated, leading to a 'lemon problem' (Scherer, 1986).[3] Inaccuracy is costly when synergies do not occur and justifications are developed *de novo* (Haspeslagh and Jemison, 1991). Agreement addresses problems of complexity by improving decision quality and reducing uncertainty. Complexity will be an issue where firms are large and differentiated, when major differences exist between firms in their technologies and markets, and when an acquisition strategy calls for operational rather than managerial or financial synergies.

Stress

Most acquisitions will induce some stress in managers and employees. Stress comes from the stakes of acquisitions and the difficulty of making accurate judgements. For employees, especially of the acquired firm, stress also results from general uncertainty about the future of the firm.

[2] Acquisition integration comprises the activities involved in the strategic and administrative combination of firms after an ownership change.

[3] This problem refers to situations in which asymmetric information creates a hazard for the buyers when quality differences cannot be ascertained in advance, but are known by sellers (Akerlof, 1970).

Conflicts during integration are common (Buono, Bowditch, and Lewis, 1988), as is management turnover (Walsh, 1988), both of which will exacerbate stress. Agreement will reduce stress and improve the motivation to implement decisions.

While strategies for making acquisitions have focused on synergies and value creation, strategies for implementing them have focused on avoiding the costs of integration (Haspeslagh and Jemison, 1991). Perhaps this is why performance issues are not well addressed in research and why acquirers often report that successful acquisitions operate with relative autonomy (Datta and Grant, 1987). While economic rationales for acquisition imply that agreement is important, the intergroup context in which integration occurs works against agreement.

Agreement and intergroup relations

Despite the tacit acknowledgement of intergroup dynamics in studies of acquisitions, intergroup theory has not been explicitly used to understand the problems of agreement that occur during integration (cf. Buono and Bowditch, 1989; Haspeslagh and Jemison, 1991). Intergroup theory concerns relationships between groups, as well as those between sectors or units of an organization and the enterprise as a whole (Miller and Rice, 1967; Alderfer, 1977; Tajfel and Turner, 1979). Hierarchical and lateral relations of varying degrees of interdependence are involved. Intergroup relations, even when occurring between individuals, are based on group or sector memberships rather than individual characteristics or personal relationships.

During integration, managers from acquired and acquiring firms must shift from the transactional (Baker, 1990) or even competitive modes of activity that characterized their preacquisition activities to a more cooperative and problem-solving mode of interaction. Difficulties in moving towards a cooperative mode of activity are related to a shift from an interorganizational relation (Whetten, 1987) between separate firms to a series of intergroup relations within a merged firm (Miller and Rice, 1967; Alderfer, 1977), in which cooperation is needed to reach common goals. Agreement between firms on the relative importance of objectives invokes higher order goals that may mitigate competitive intergroup dynamics and facilitate cooperation and information sharing.

From an intergroup perspective, managers represent sectors or functions of the organization and interact with other managers on behalf of their respective task systems. While managers often act on their own behalf, it is in this representative role that they collectively act for the organization regarding strategic decisions and their implementation. Similarly, it is managers representing the firm as a whole who must take the individual personnel actions that implement strategic decisions.

This change in definition of organizational boundaries that follows an acquisition implies a cognitive shift in the *social identification* of acquirers and acquirees that can distort perceptions and compromise decision quality (Tajfel, 1984).[4] Social identification can arise from group membership alone (Allen and Wilder, 1979; Doise, 1978). Simply renaming a firm after an acquisition can produce significant changes in the identification of members. Reorganization further changes boundaries, alters group memberships, and redefines the status differences from which individuals derive their social identity.

People strive for a positive social identity in three ways. First, they may change group memberships. Second, their group characteristics may change and thus change their social identities. Finally, people may change their evaluations of existing group characteristics, (Ashforth and Mael, 1989). In an acquisition, all three may occur, but the last way, a change in evaluations without a change in actual characteristics, shows the influence of perceptual distortions.

A characteristic intergroup dynamic evident during integration is the development of generalized and asymmetric status relationships between firms. These are similar to the majority-minority relations studied by intergroup theorists (Kelly, 1990). In the case of acquisitions, previously stable status differences can be destabilized. Destabilization increases concern with

[4] Social identification is the process through which the individual derives part of his self concept from his membership in groups and from the value and emotional significance attached to these memberships (van Kippenberg, 1984). It is enhanced by the distinctiveness and prestige of the group and the relevance of outgroups through social comparison as well as by group formation variables such as interpersonal interaction and shared goals (Ashforth and Mael, 1989).

intergroup relations (van Kippenberg, 1984). Acquiring firm members are threatened by the acquisition and attempt to reestablish positive intergroup differences by accentuating their strengths and/or uniqueness, even at the cost of denigrating the acquired firm and devaluing its contribution to the combination. Agreement between firms may work against agreement within firms, suggesting a positive association between group identification and intergroup differentiation (Kelly, 1990).

The contrast of agreement within v. between firms requires more attention. During integration there are, in effect, two identities within one firm. This suggests the need to further elaborate the agreement construct. A fourth variable, *internal agreement*, concerns within group rather than between group agreement. It is the extent to which an individual agrees with his own organization. This is analogous to actual agreement, but the reference group is different. Prior studies of acquisitions have considered how agreement within a management team improves decisions (Haspeslagh and Jemison, 1991).

It is unlikely that individuals will fully agree with either their own or with the other organization in an acquisition. Cooperation does not require goal unanimity. Cooperation is instead facilitated by the validation of the objectives and characteristics of one group by another (van Kippenberg, 1984), and is aided by differentiated goals so that each group identifies subgoals of value in cooperative activity. This mutual appreciation of diversity, while somewhat counterintuitive, is important for success in acquisition implementation.

Success expectations and acquisition performance

When studies of integration have addressed performance and effectiveness issues, they have usually focused on the year following an acquisition. During this time, it is difficult to measure performance, since objectives are unclear, requisite data are unavailable (often requiring the use of single informant surveys), and comparison groups are lacking. These problems are common in efforts at assessing organizational effectiveness (Cameron and Whetten, 1983).

While we suspect that agreement influences the overall performance of the successor firm, it is perhaps too ambitious to expect that the linkage of agreement and performance will be clearly identifiable and separable from alternate explanations, given common measures of profitability or stock price changes.[5] There are too many other factors influencing overall performance. We address performance through the intermediate variable of managerial success expectations.

Managerial expectations of an acquisition's success potential are plausible intermediate performance measures. The link between agreement and success expectations is through expectancy theories of motivation (Feather, 1982), which argue that success expectations reflect the judgements an individual makes concerning the extent to which his or her effort on the job will lead to desired levels of performance (the effort to performance likelihood). The stronger the link between effort and performance, the more likely it is that an individual will be highly motivated on the job. Since the objectives of managers are more likely than those of other employees to be realized, due to position power and discretion, their expectations of success are more plausibly associated with performance.[6]

The relationship between agreement and success expectations is complicated by two factors. First, there are multiple sources of social identification in organizations. How the number of sources influences expectations is unclear. In service firms, such as hospitals, demands from professional identities compete with organizational and task requirements. A second factor that influences the association between agreement and success expectations is the extent of involvement in decisions. Involvement influences accuracy through access to information. It also influences how personal goals are tied to outcomes, since involved individuals have a higher stake in a decision. Involvement also concerns

[5] The issue of how integration affects acquisition performance is not settled (Datta, 1991). Haspeslagh and Jemison (1991, Appendix B) show the lack of agreement among scholars. Difficulties in measuring performance and the difficulties of using self-reports of performance are part of the reason for the trend in studies of acquisition results towards using stock price changes (Fowler and Schmidt, 1989; Seth, 1990) or indicators of divestiture (Scherer, 1986; Porter, 1987).

[6] Finkelstein and Hambrick (1990) show that, among managers, those with more discretion will be more likely to implement their chosen strategies than those with less discretion.

intergroup relations, since involved decision makers often work at critical intergroup boundaries in a situation.

To develop our study hypotheses, we consider the objectives of an acquisition as the set of issues for which agreement is important. Given this focus, the places where firms interact during integration are of most interest, since these are where the behavioral consequences of agreement or disagreement are apparent. In what follows, perceived and actual agreement concern agreement between acquired and acquiring firms, but not within firms. Agreement with one's firm is called internal agreement, while perceived agreement with one's own firm is not assessed. This focus was chosen on the premise that a careful study of perceived v. actual agreement would be sufficiently difficult within the limited context of an acquisition. Further study of strategic decision maker agreement, however interesting theoretically, was not feasible, due to both design and resource requirements.

We expect that our four dimensions of agreement are empirically distinct and that the judgemental tasks and levels of analysis involved in each will differ. Perceived agreement involves a comparison of two positions held by an individual. Actual agreement and internal agreement involve comparisons between an individual's position and some collective orientation not reducible to an individual's position. Accuracy compares an individual's beliefs about someone else with a collective orientation. Because of these differences, we generally present separate subhypotheses for each type of agreement.

A first question is whether respondents will differ on agreement variables according to their organizational affiliation. Differences between perceived and actual agreement are possible. Individuals from both the acquirer and acquiree, out of a strong identification with their firm, may presume that members of the other firm agree with them. The reverse could happen if uncertainty regarding the other firm or past problems with other acquisitions lead decision makers to assume more disagreement than actually exists. Kelly's arguments (1990: 584–585) on the need of minority group members to differentiate themselves from the majority group suggest that perceived agreement will be lower in the acquired firm than in the acquirer.

Agreement within management teams of each firm can also change after an acquisition. Changes are more likely for acquired firms, since a change in ownership disrupts the entire acquired firm but only part of the acquirer. Disruptions heighten the focus of acquired firm managers on self interest (Hirsch, 1987), increasing the likelihood of political behavior. Individuals within the acquirer face fewer threats from the acquisition and thus have fewer reasons to disagree over it with their managers and colleagues. These points suggest the following hypotheses:

H1a: Perceived agreement will differ by organizational affiliation.

H1b: Actual agreement will differ by organizational affiliation.

H1c: Accuracy will differ by organizational affiliation.

H1d: Internal agreement will differ by organizational affiliation.

We have identified three sources of social identification: profession, organization, and tasks. These influence the reactions of employees to acquisition by introducing perceptual biases. The direction of this influence is unclear. Of these sources, we expect an association for internal agreement. A major theme in organization theory distinguishes positions for which influence comes from knowledge and expertise v. positions with influence stemming from formal authority and position prerogatives (Scott, 1981: 277–279). Doctors have fewer reasons to agree with their own firms than do hospital managers, since the professional affiliations of doctors are more important to them. This suggests the following hypothesis:

H2: Internal agreement will differ by professional roles or occupational tasks.

We expect that accuracy will increase with decision maker involvement in integration activities. Involvement brings members of the acquirer into contact with members of the acquired firm. Contact increases information and moderates distortions. Thus perceived agreement may also change, along with accuracy. The direction of change is unclear. An escalating commitment

argument (Staw, 1976) suggests a positive association of perceived agreement and involvement. Perceived agreement could be reduced with involvement if major differences in objectives are present and interactions are negative in tone.

Since actual agreement is explainable in part by decision maker interests, it is unlikely that it will be moderated much by involvement, unless contact forces a reevaluation of objectives. Involved individuals represent their own organizations. Their objectives depend on factors beyond interactions with members of the other firm. The level of agreement within the management teams may be strengthened by involvement, since the contact situation may threaten social identification.[7] In such a setting, individuals could reaffirm their agreement with their own firm. Conversely, the chance to form alliances with managers in the other firm may lower the level of internal agreement. These points suggest the following hypotheses:

H3a: Perceived agreement will differ according to the extent of involvement in integration.

H3b: Actual agreement will differ according to the extent of involvement in integration.

H3c: Accuracy will differ according to the extent of involvement in integration.

H3d: Internal agreement will differ according to the extent of involvement in integration.

The relationship between contact and internal agreement presumed by Hypothesis 3d raises the general issue of an inverse association between internal agreement and perceived agreement that is suggested by intergroup research (Kelly, 1990). Specifically, to the extent that individuals value identification with their own group, they will reaffirm that identification, potentially at the expense of the other group, when it is threatened. This point is a specific instance of the more general observation of McCann and Galbraith (1981) that there is an inverse relationship between intragroup and intergroup interactions. This suggests the following hypothesis:

H4: Internal agreement will be inversely associated with perceived agreement, controlling for organizational affiliation.

Success expectations will be associated first with the level of personal value that an individual attaches to a set of activities. Controlling for this, success expectations will be associated with agreement. While perceived agreement is not ncessary in all aspects of integration, the need to attain some economic benefits suggests that there are areas where it is desirable. As mentioned above, the association of perceived agreement and success expectations could be negative if perceived and actual agreement differ, resulting in conflict. Accuracy will be similarly associated with expectations. If actual agreement is low, then accuracy will be negatively associated with expectations, while the reverse is expected if actual agreement is high.

From prior research on agreement, actual agreement is expected to be positively associated with success expectations. Since internal agreement is akin to actual agreement, a positive association of it and success expectations is also expected. If operating synergies are critical to an acquisition, the relationship of internal agreement and success expectations could be negative. For example, if high levels of internal agreement were present in both firms, it would predict a high level of conflict during integration if there are basic differences between firms on objectives. If this conflict was anticipated, it would also be associated with reduced success expectations.

The social context of agreement will be associated with success expectations because of intergroup dynamics that are based on the task, organizational, and professional identifications of actors. While social context can impede agreement, intergroup factors can also aid agreement. The involvement of decision makers, for example, will influence the extent to which agreement occurs. Involvement will positively influence agreement in motivational and informational terms, as well as through linkage with social identification.

[7] The 'contact hypothesis' refers to the general proposition, one with a long history in social research, that contact between social units can help reduce conflict between those units. Recent studies of the contact hypothesis have found that contact can either reduce or increase conflict (Hewstone and Brown, 1986). For an extended discussion of the contact hypothesis and an empirical application to organizational analysis, see Nelson (1989).

H5: Success expectations will be a function of the personal value accorded to objectives, perceived agreement, actual agreement, accuracy, internal agreement, involvement, organization, profession and tasks.

RESEARCH DESIGN AND METHODS

A case design triangulating survey, archival, interview, and observational data is used (Jick, 1979; Yin, 1989). Questionnaire design follows Hoch (1987), taking into account the methods of Alderfer and Smith (1982) and Kelly (1990).

Case history and research setting

This summary highlights the strategic and intergroup aspects of the research setting. The hospital industry has recently undergone rapid change toward a more competitive environment (Shortell, Morrison, and Friedman, 1990). Our study concerns a hospital acquisition in a large southeastern city. Both hospitals are licensed for more than 250 beds. Research access was obtained within a week of the announcement of the combination. The acquirer is an academic medical center, whose physicians meet academic rank criteria for appointment. The acquired hospital is a community hospital with a residency program and a teaching affiliation with the state medical school. This synopsis is based on interviews with 24 senior managers in both hospitals and a review of over 400 pages of primary documents.

The acquired hospital, which initiated the combination, had a local market that was competitive and undergoing rapid consolidation. These market dynamics, along with financial difficulties and an aging medical staff, provided the impetus for an affiliation. An affiliation with a tertiary care center was sought to attract new doctors, develop new services, and improve operating efficiency. The acquirer was lead by a new management team that had, within the year prior to the acquisition, obtained autonomy from the university. It had adopted a growth strategy that included development of an affiliation network, supported by aggressive marketing.

The acquirer was located in an unprofitable local market and had recently failed in a well publicized attempt at merger with another tertiary care center, a failure blamed in part on the perceived similarity of the two medical staffs. The failure raised the acquirer's concern about its reptutation as a partner. While its strategy placed a premium on being dominant in any combination, the need to be perceived as a good partner made it important not to be seen as overly controlling. Given that managers in the acquired firm anticipated retaining control, it is not surprising that governance arrangements were left unsettled at the start of integration. A joint management committee was developed that became the locus of intergroup conflicts.

Advance analysis was done by the acquirer, but was not integrated into the decision process. Human resource issues were not considered and the financial analysis underestimated the size of deficits for the acquired hospital. Analyses were overly optimistic. Initial decisions were made quickly under secrecy and time constraints. Integration problems escalated when the chairman of the acquired firm, who was a key member of the medical staff, had a heart attack that led to the announcement of the acquisition being made by the nonphysician chief executive officer (CEO). This made the chairman lose credibility with the medical staff.

A problem throughout the integration was that employees and medical staff of the acquired hospital were suspicious of the acquirer. This is a common problem in acquisitions (Marks, 1982) and was apparent in interviews conducted by acquirer staff with the medical staff of the acquired hospital immediately following the announcement of the combination. Members of the acquired medical staff were concerned that the acquirer would obtain patients on referral and not send them back.

Integration was punctuated by conflict and cooperation. Differences in views of the combination are apparent in how members of the acquirer described the deal as an *acquisition*, while members of the acquired hospital described it as an *affiliation*. At the acquirer, differences were reflected in difficulties with faculty appointments from the acquired hospital. These were sufficiently serious that an associate dean was hired to manage the medical staff interface. Conflict in the acquired firm peaked when the CEO's office was vandalized, apparently by colleagues. Conflicts in the acquirer were dramatized by the resignation of the manager hired to chair the joint management committee of the acquired hospital.

Variables

Agreement scores are within-subject correlations of individual ratings of the importance of objectives and mean group ratings of the same objectives. This method is consistent with studies of projection and false consensus (Dawes, 1990; Hoch, 1987; Brehmer, 1986). Four variables were constructed. *Perceived agreement* correlates one's own ratings with one's estimates of ratings in the other organization. This is the reverse of Kelly's differentiation variable (1990). *Actual agreement* correlates one's own ratings and the mean ratings of the other organization. *Accuracy* correlates one's estimates of ratings in the other organization with the actual mean scores. Finally, *internal agreement* correlates one's own ratings with the mean ratings of one's own organization, analogous to Kelly's identification variable (1990).

What we call objectives, the items for which ratings were elicited, comprise the formal and informal purposes for the acquisition. Most of these had been communicated throughout both organizations and were accessible to all respondents. The objectives used in our study combined items that were apparent in formal documents with items that emerged from interviews with decision makers in both organizations. Implementation steps were in the process of being determined during data collection and thus could not be studied prospectively.

Agreement is analyzed across items (objectives), consistent with Hoch (1987), who argues that the interpretation of within item measures is confounded by substantive concerns around an item. Controls include: organizational affiliation (acquirer v. acquiree), professional background (M.D. v. non-M.D.); tasks (administrative, clinical, joint); and involvement with integration. Involvement (high, medium, low) was assessed for respondents by senior executives of each hospital. To address issues of how agreement variables are related to performance, the associations of perceived agreement, actual agreement, accuracy, and internal agreement with measures of the expectations that respondents had for the success of the acquisition were studied through the use of multivariate analysis of variance (MANOVA) procedures.

Two measures are used to assess success expectations—*aggregate expectations* and *overall expectations*. These measures address difficulties in operationalizing performance noted above, especially problems in separating overall judgements from the aggregated assessments of success for particular activities. Pairing a simple measure of expectations with an aggregate measure makes results about expectations less likely to be artifacts of overall correlations across responses, although some common method problems are unavoidable.

Aggregate expectations is the mean likelihood of success across the 14 acquisition objectives. For each objective, respondents were asked to rate (on 10-point scales): (1) the likelihood of the objective being accomplished in the short term (defined as 2 years or less), and (2) the likelihood of the objective being accomplished in the long term (defined as more than 2 years). Because of their high intercorrelation (0.7), short- and long-term success expectations were averaged to provide a single measure of expectations for each objective. These were then aggregated across objectives.

Overall expectations is an estimate of expectations of success, without reference to particular objectives, calculated on a 10-point scale. This variable is intended to reflect the success expectations that are not reducible to individual values on particular objectives. Because overall and aggregate expectations variables are likely to be correlated to some degree (0.58 in our results), overall expectations in the analysis that follows is controlled for aggregate expectations so that the two are independent by construction.

Personal value measures the overall personal importance that respondents attached to acquisition objectives. It is the mean of the ratings of importance that were provided by each respondent for the 14 objectives.

Sample and data collection

Our initial sample included all individuals with clinical or administrative positions in the acquired or acquiring hospital who had the authority to make decisions germane to acquisition integration. These were determined by the top managers of each organization. Among the sample were both chairmen, chief executive officers, chief operating officers, chief financial officers, and directors of human resources. Medical staff respondents included the heads of the two medical staffs, the acquirer's clinical chairmen, the heads of specialty sections for

both organizations (surgery, OB/GYN), and the directors of nursing.

Our sample differs from those used in other agreement studies, such as Hoch (1987). We start with the entire set of decision makers in these two hospitals who are concerned with the acquisition. It is thus not really a sample at all and is certainly not random. Unlike Hoch, the ratings elicited here are not general attitudes about which respondents have only passing interest, but instead concern activities related to respondents' current job responsibilities and employment security. Respondents can be expected to have strong reasons for their responses and are uniquely informed about the activities they rated.

Where possible, questionnaire development incorporated Alderfer and Smith's (1982) methodology. Twenty-four semistructured interviews and an archival review generated a list of objectives. Interviews were conducted by two investigators, took place in a respondent's office and, where possible, were recorded. An iterative approach was taken to questionnaire development that paid attention to the representation of key groups within both organizations. The fourteen items obtained from this process are listed in Table 1.

Respondents were asked (10-point scales) for: (1) importance ratings for the 14 objectives, and (2) estimates of the importance of each objective for the other hospital. Respondents were also asked to rate the expectations of acquisition success (10-point scale). A 10-point format was used to allow for a wide range of responses, since the research setting would not permit extensive retesting. No midpoint was used on scales because, by intention, no negative importance ratings were elicited. The sensitivity of the research setting made it necessary to indirectly identify differences between the two hospitals on particular objectives from a comparative analysis of aggregated responses rather than directly in survey responses.

Data collection occurred 1 year after the acquisition. Responses thus represent the judgements of decision makers in the midst of integration. Conflicts between the two hospitals during early integration activities, along with the iterative process for questionnaire development, made a delay in data collection necessary. The implications of this delay for reliability are discussed below.

While we attempted to survey the entire population of decision makers in the two hospitals, we failed to get responses from some individuals. 114 questionnaires were mailed—65 going to the acquirer and 49 to the acquiree. 84 responses were obtained for a response rate of 74%. Missing items made the usable sample 73.[8] Usable responses by hospital, profession, and tasks (clinical, administrative, joint) are shown on Tables 2a and 2b. Late responses were analyzed as proxies for nonresponses and no late response effect was identified.

Validity and reliability

Criterion and content validity were emphasized in our use of Alderfer and Smith's (1982) organic questionnaire development process. Success in developing items is suggested by the lack of additional objectives specified by respondents.

An examination of the underlying factor structures for each hospital shows that they are similar in the number and composition of factors, indicating that respondents interpreted questionnaire items in generally similarly ways. Objectives concerning specific medical programs, such as those for heart and cancer, grouped together, as did objectives concerned with the expansion of hospital markets, through the growth of referral networks, accessing of new market areas, and building of physician practices. Other groupings concerned the overall strength of the institutions and the overall quality of medical care provided. With the overall number of respondents being fairly low, these comparisons are admittedly rough ones.

Test-retest reliability is difficult to assess, since variation in responses can result from changes in the phenomena under study as well as from measurement errors. Responses obtained at different times will differ in their stability. Responses obtained at the time an acquisition is announced, for example, could be highly unre-

[8] Doctors from the acquirer with primarily clinical duties were most affected by nonresponses and missing data. These were the least important members of the sample, however, in that most integration responsibilities in the acquirer were held by individuals with mixed clinical and administrative duties, such as the clinical section heads. They were oversampled to begin with. The differentiated structure of the acquirer, with its large teaching/research component is the reason for this allocation of authority.

Table 1. Descriptions of questionnaire variables*

Objectives	
1) *New doctors*	Attract new physicians to the acquired hospital. These physicians include both those completing their residencies and those with established practices.
2) *Medical education*	Develop the acquired hospital as a site for on-site graduate and undergraduate medical education.
3) *Financial performance*	Improve the performance of both hospitals on financial and accounting criteria as a result of the acquisition.
4) *Build medical practices*	Help M.D.s attending at both institutions to develop their individual practice base.
5) *Access to new markets*	Allow the acquiring hospital access to a geographically new market for its services through the acquisition.
6) *Quality of care*	Use the acquisition as a basis for improving the quality of medical care provided to patients at both hospitals.
7) *Heart program*	Build a joint cardiac care unit.
8) *Cancer program*	Build a joint oncology treatment program.
9) *Referrals*	Build patient referral patterns between the hospitals.
10) *Reputation*	Enhance the status of both the acquired and acquiring hospitals among area competitors.
11) *Research*	Use case flow in the combined hospital to generate research opportunities in the acquiring hospital.
12) *Sharing expertise*	Develop joint programs of medical care and research that use complementary skills from each hospital.
13) *Sharing services*	Realize cost-savings in supply, transportation, maintenance, negotiation, advertising, etc. from combining hospitals.
14) *3rd parties*	Improve the negotiating position of the combined hospitals with 3rd party payors.

Performance measures: Defined in text
*All variables are measured on a 10-point (low = 1, high = 10) scale.

Table 2a. Sample characteristics: Hospital by profession

	Hospital Acquired	Acquiring	Total
Profession			
Medical staff	20	18	38
Administrative staff	16	19	35
Total	36	37	73

Table 2b. Sample characteristics: Hospital by tasks

	Hospital Acquired	Acquiring	Total
Tasks			
Clinical	11	4	15
Administrative	15	16	31
Joint	10	17	27
Total	36	37	73

liable in the acquired firm, due to anxiety over the acquisition, coupled with information limitations regarding the intentions of the acquirer. In 1 year, information can be diffused throughout both firms, while affected employees develop stable beliefs and expectations.

The reliability of agreement measures was assessed by calculating 14 sets of alternative agreement measures, using all combinations of 13 $(n-1)$ objectives.[9] If estimates are reliable, they should not be greatly affected by the removal of ratings for any one objective. The same ordinal relationships among agreement variables as were reported on Table 4a were found for these 14 sets of estimates.

These results suggest that agreement variables are fairly reliable. The removal of an objective significantly changed the difference between

[9] For more on Jackknife estimators, see Mosteller and Tukey (1977).

Table 3. Own ratings and estimates of others (by variables across subjects)

	Own		Other				
Variables	Mean	S.D.	Mean	S.D.	Corr.	p	n
New doctors	6.60	3.24	6.88	2.82	−0.312	0.002	82
Medical education	6.00	2.67	6.09	2.81	−0.073	0.261	80
Financial performance	7.95	2.47	7.85	2.42	−0.010	0.466	81
Building practices	7.78	2.03	6.73	2.52	−0.147	0.095	81
New markets	7.88	2.39	6.42	3.01	−0.083	0.230	81
Quality care	5.01	3.36	5.84	2.76	0.293	0.004	81
Heart program	8.58	1.93	8.07	2.29	0.012	0.459	77
Cancer program	7.85	2.16	8.18	1.84	0.116	0.159	77
Referrals	6.60	2.81	6.83	2.73	0.242	0.014	82
Reputation	6.77	2.99	7.18	2.93	−0.126	0.130	82
Research	5.04	3.10	5.16	3.09	0.080	0.240	80
Sharing expertise	5.35	3.19	5.92	2.89	−0.150	0.088	83
Sharing services	6.68	2.41	6.28	2.53	0.387	0.000	81
3rd Parties	6.96	2.75	6.19	2.99	0.718	0.000	81
Overall expectations	6.79	1.69					
Aggregate expectations	5.52	1.58					

perceived and actual agreement for only three items (research; new markets; heart program). For each, the change is consistent with the facts of the research setting. The heart program was a matter of importance for both organizations and its removal lowers agreement. The development of new markets, on the other hand, was important to the acquirer but not the acquiree. Its removal increases agreement. Finally, both organizations placed a low emphasis on research as an acquisition objective and removing it reduced agreement.

RESULTS

Means and standard deviations of responses for individual objectives are shown on Table 3. Differences between organizations are significant for most objectives, although they are much less so if a rank order analysis is used.[10]

Results for perceived agreement, accuracy, actual agreement, and internal agreement are reported on Table 4a. Correlations among these variables are reported on Table 4b. The mean correlation of one's own rating with estimates of others is 0.13. One-fourth of the subjects (twice the number expected by chance) have correlations exceeding 0.37 (paired t-test; $p \leq 0.1$). Actual agreement is higher than perceived agreement ($p = 0.04$). Respondents can improve their accuracy by assuming more similarity with the other hospital. Accuracy is higher than actual or perceived agreement, with half the scores significant at $p \leq 0.05$.

Differences in agreement scores by organization, profession, and task are reported on Table 5. These differences are the concerns of Hypotheses 1a through 1d and Hypothesis 2. Hypotheses 1a, 1b, and 1c, which predict associations between organizational affiliation and perceived agreement, actual agreement, and accuracy are not supported. Responses differ by organization only for internal agreement. This is significant and in the direction predicted by Hypothesis 1d—pressures of integration disrupt agreement for the acquired firm. No associations are identified with profession or task. In particular, Hypothesis 2, which predicts an association of internal agreement and professional roles and tasks, is not supported.

Differences by involvement are reported on Table 6. These results indicate that the first and second parts of Hypothesis 3 are not supported,

[10] The correlation between the two sets of mean scores is 0.29 ($p = 0.16$). A Wilcoxson signed rank test (Conover, 1980: 280) between the two sets of means is not significant. Note that correlational measures, such as used for agreement variables, are insensitive to general differences in level between organizations.

Table 4a. Perceived and actual agreement, accuracy, and internal agreement results (within subjects, across variables)

	Perceived agreement	Accuracy	Actual agreement	Internal agreement
Mean	0.128	0.438	0.196	0.558
S.D.	0.333	0.248	0.251	0.228
Range	(−0.63, 0.79)	(−0.38, 0.89)	(−0.66, 0.72)	(−0.31, 0.91)
# of positive scores significant at:				
$0.05 \leq p \leq 0.1$	7	12	7	13
$0.01 \leq p \leq 0.05$	5	16	7	13
$p < 0.01$	6	19	4	36
Total	18	47	18	62
N	73	73	75	75

Individual correlations based on 14 within-subject pairs of observations. Significance levels represent approximate correlations of 0.37, 0.45, and 0.60.

Table 4b. Correlations among agreement variables

Variable	#2	#3	#4
1. Perceived Agreement	0.13	0.39	−0.20
2. Accuracy		0.07	0.21
3. Actual Agreement			0.23
4. Internal agreement			

is identified between internal agreement and involvement, with both medium and high levels of involvement being associated with higher levels of internal agreement.

Table 4b shows a significant correlation between perceived agreement and internal agreement of −0.20. The first-order partial correlation of perceived agreement and internal agreement, controlling for organizational affiliation, is −0.16, which is marginally significant ($p = 0.09$). This

Table 5. Agreement variables by hospital, profession, and tasks[a]

Variable	Profession		Hospital		Tasks		
	Medical/Administrative		Acquired/Acquiring		Clinical/Administrative/Joint[b]		
Perceived agreement	0.11	0.14	0.17	0.09	0.10	0.16	0.10
Accuracy	0.39	0.48	0.42	0.46	0.41	0.49	0.39
Actual agreement	0.16	0.23	0.17	0.23	0.10	0.24	0.20
Internal agreement	0.56	0.56	0.46	0.66*	0.56	0.58	0.54

*The difference between means is significant at $p \leq 0.001$

[a]*t*-tests were used to compare means for hospitals and professions. One-way analysis of variance was used to compare means for tasks.

[b]Joint tasks are those for which the incumbent may have both clinical and administrator duties. The position of clinical chairman is an example of such a task.

while the third and fourth parts are supported. Hypothesis 3a is not supported, in that the association of involvement and perceived agreement is negative, but marginally insignificant. Hypothesis 3b is also not supported, in that actual agreement is not associated with involvement. Hypothesis 3c is supported by the significant positive association between involvement and accuracy. Finally, a highly significant association provides lukewarm support for Hypothesis 4, that internal agreement is inversely associated with perceived agreement.

Tables 7a and 7b report MANOVA results for two measures of success expectations. Table 7a uses aggregate expectations, while Table 7b uses overall expectations (controlled for aggregate expectations). Organization, task, and involvement are main effects. Predictors include personal

Table 6. Agreement variables by extent of involvement

Variable	Extent of involvement				
	High	Medium	Low	*F*	*p*
Perceived agreement	− 0.039	0.147	0.175	2.29	0.10
Actual agreement	0.169	0.204	0.201	0.09	0.91
Accuracy	0.584	0.432	0.392	3.38	0.04*
Internal agreement	0.605	0.737	0.485	8.85	0.00**
N	14	16	43		

*Paired comparison tests identified significant differences between high and low involvement groups.
**Paired comparison tests identified significant differences between the low involvement group and both the high and medium involvement groups.

value and the four agreement variables.

With aggregate expectations, no effects are found for involvement, tasks, or organization. Of the regression variables, personal value is significant and positive, while actual agreement is marginally significant and negative. This indicates that aggregate expectations are predicted by one's own values towards objectives and the extent to which one actually agrees with the other organization. No other significant results were identified. For overall expectations, however, significant effects are found for tasks and involvement. Of the regression variables, perceived agreement is significant and positive, while accuracy is significant and negative.

These results support Hypothesis 5. Different aspects of agreement are associated with success expectations, although not consistently across different aspects of agreement. Perceived agreement is positively associated with overall success

Table 7a. MANOVA results. Aggregate success expectations by hospital, profession, tasks (personal value[a], perceived agreement, actual agreement, internal agreement, and accuracy as independent variables)

Source	SS	d.f.	MS	*F*	*p*
Within cells	59.38	54	1.12		
Regression	52.32	5	10.46	9.34	0.000
Hospital	1.00	1	1.00	0.89	0.350
Involvement	2.15	2	1.07	0.96	0.390
Tasks	2.09	3	1.05	0.93	0.400
Model	57.56	10	5.76	5.14	0.000
Total	116.94	64	1.86		

R-Squared = 0.492
Adjusted *R*-Squared = 0.396

Regression analysis

Covariate	Beta	Std. Err.	*t*-value	Sig.
Personal value	0.57	0.12	5.31	0.000
Accuracy	0.06	1.85	0.46	0.650
Perceived agreement	0.21	0.59	1.56	0.124
Internal agreement	−0.05	0.91	− 0.44	0.665
Actual agreement	−0.19	0.67	− 1.72	0.091

[a]Personal value is the sum of the ratings provided by respondents indicating the importance they placed on objectives.

Table 7b. MANOVA results. Overall success expectations[a] by hospital, profession, tasks (personal value[b], perceived agreement, actual agreement, internal agreement, and accuracy as independent variables)

Source	SS	d.f.	MS	*F*	*p*
Within cells	61.74	54	1.16		
Regression	7.79	5	1.56	1.34	0.263
Hospital	1.65	1	1.65	1.42	0.239
Involvement	7.56	2	3.78	3.24	0.047
Tasks	14.13	2	7.06	6.06	0.004
Model	31.13	10	3.11	2.67	0.010
Total	92.87	64	1.47		

R-Squared = 0.335
Adjusted *R*-Squared = 0.210

Regression analysis for within cells error-term

Covariate	Beta	Std. Err.	*t*-value	Sig.
Personal value	− 0.05	0.12	− 0.37	0.716
Accuracy	− 0.41	1.89	− 2.40	0.020
Perceived agreement	0.33	0.60	1.88	0.065
Internal agreement	− 0.06	0.92	− 0.48	0.630
Actual agreement	0.02	0.68	0.16	0.872

[a]Controlled for association with aggregate success expectations
[b]Personal value is the sum of the ratings provided by respondents indicating the importance they placed on objectives.

expectations, while actual agreement is inversely associated with aggregate success expectations.

DISCUSSION

In this paper, we have tried to further develop the idea of decision maker agreement. To do this, we specified four dimensions of agreement—perceived agreement, actual agreement, accuracy, and internal agreement—and considered how these aspects of agreement help explain the expectations of success that respondents had for a hospital acquisition. We have also attempted to assess the social context in which agreement develops. Our results suggest that taking actual agreement as the sole dimension of agreement will result in a failure to capture important variation on other aspects of agreement. They also suggest that intergroup dynamics link individual and group levels of analysis, as seen in the association we identified of involvement with accuracy, internal agreement, and expectations of success.

Agreement variables do not appear to differ by organization, profession, and tasks. Responses differ by organization only on internal agreement. This is significant in the direction anticipated—that integration reduces internal agreement for acquired firm members. An alternative explanation for this particular result, that there was less within firm agreement prior to the acquisition, is not supported by documentary and interview evidence that suggests high levels of within firm agreement prior to the acquisition. This perceived high level of agreement was an initial point of attraction for the acquirer.

That perceived agreement does not differ by organization does not necessarily conflict with the idea that intergroup dynamics help explain agreement. Hypothesis 1a was suggested by Kelly (1990) in the context of majority–minority factions in a political party. While the relationship between acquired and acquiring firms has similarities to that of competing factions, the acquiree is unlikely to become the 'majority' in the combined firm. Thus, the need to accentuate differences from the acquirer is tempered by the recognition of the likelihood of assimilation. Issues of assimilation and acculturation have been recog-

nized in research on integration (Sales and Mirvis, 1984; Nahavandi and Malekzadeh, 1988; Haspeslagh and Jemison, 1991).

The lack of associations with organization, profession, and task suggests that it is the manner in which different sources of social identification come together around the area of strategic interest that will determine the role of social context. The importance of context is apparent in the role of involvement in the development of agreement (Hypotheses 3a to 3d). Involved decision makers estimate more accurately the positions of individuals in the other firm, due to their access to information. They also have higher internal agreement, consistent with the contact hypothesis of intergroup theory, that contact with the other organization increases the salience of intergroup differentiation. Contact disrupts social identities within acquired and acquiring firms. These identities are reinforced by organization members with potentially dysfunctional consequences for the acquisition.

These results suggest that the relationship of involvement and agreement is complex and that involvement has positive and negative implications for integration. The lack of association of involvement with actual agreement suggests that contact between organizations does not change the orientation of individuals towards the objectives of a combination, contrary to prescriptions (cf. McCann and Gilkey, 1988).

Knowing the other party more accurately does not, by itself, lead to a convergence of objectives. By fostering accuracy, however, contact can create an environment in which differences are respected and mutuality can develop over the long term as parties work together (Haspeslagh and Jemison, 1991). Accurate information about the state of integration relationships also helps individuals cope with the often difficult conditions of integration (Schweiger and DeNisi, 1991).

Hypothesis 4 develops the unanticipated consequences of intergroup dynamics and suggests an inverse relationship between actual and internal agreement. This is a simple test of the counterintuitive implications of intergroup theory for acquisitions. The negative correlations obtained in this study provide modest support for Hypothesis 4 and replicate Kelly's finding of a positive association between group identification and intergroup differentiation (1990).

Agreement is related to judgements of success, as expected by Hypothesis 5, although how depends on which aspects of agreement and which judgements of success one considers. Aggregate expectations, controlling for personal value, are predicted by actual agreement. The negative coefficient on actual agreement suggests that differences between parties on objectives are positively associated with success expectations, consistent with the idea that synergy involves a complementary relationship between firms in which disagreement is likely, and probably desirable, on matters for which one firm has superior knowledge or experience relative to the other.

In contrast, overall expectations are determined by perceived agreement and accuracy, along with the contextual factors of task and involvement. As judgements move from specific items to an assessment of the general relationship between acquired and acquiring firms, issues of accuracy and the social context in which agreement develops are more important. For these performance judgements, an overall assessment of a common direction and purpose between firms appears desirable.[11]

A common theme in these results concerns the importance of level of analysis for understanding the role of agreement in acquisition integration. First, acquisition objectives that are reasonable at an organizational level may prompt group dynamics that work against their realization. Second, when success expectations for an acquisition are elicited at a global level, they are positively associated with the level of perceived agreement between acquiring and acquired firms. When expectations are aggregated from responses to particular objectives and activities, however, they are inversely associated with actual agreement and not related to perceived agreement. Third, while accurate information may help individuals cope with the uncertainties of the

[11] Some points can be made about subsequent performance. One year after data collection, the acquirer was performing well in terms of accounting returns, occupancy, and new program development. Acquirer managers, however, did not think that the acquisition had fulfilled its objectives or was contributing to acquirer performance, in spite of progress on some dimensions. The deficit was controlled by changes in accounting procedures and by staff reductions. New programs for cancer and heart treatment had been established and admissions on such basic services as deliveries had improved. The hiring of new doctors was proceeding slowly. There were misgivings in the acquirer management team on the prospects for long-term success.

integration period, it is not associated with a convergence of objectives between organizations and can actually harden differences if organizational objectives sharply diverge. Finally, actual agreement within a management team is inversely associated with agreement across organizations, consistent with intergroup theories.

CONCLUSIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Decision maker agreement

Agreement is a complex construct that spans individual and collective levels of analysis. While perceived agreement is an individual judgement, actual agreement and accuracy are partly collective. This intuition is supported by our results. While studies of particular aspects of the agreement are useful, they need to show which aspects of agreement are being addressed and which are not.

The social context in which agreement develops is important. Agreement variables are related to the intergroup relationships in which agreement develops, through the idea of involvement. Involvement can influence agreement in multiple ways. While associated with accuracy, it is also associated with internal agreement, which in turn is inversely associated with perceived agreement.

Agreement judgements are associated with performance, as suggested by prior research. The association, however, is complex and depends on which aspects of agreement are considered, which aspects of performance are assessed, and which time period is used. While other studies have attempted to link agreement with broader indicators of organizational performance, it is difficult to identify in advance the theoretical mechanism by which such a link functions, even for limited intermediate performance measures, such as are employed here. Future research may be able to increase what is known about the relationship between agreement and performance by narrowing the focus of the performance dimension and better specifying the agreement construct.

This approach to studying agreement can be extended beyond the case of acquisition integration to both intra and interorganizational contexts, although the broader the range of issues for which agreement is of interest and the more complicated the group context, the more difficult such situations will be to study. Between organizations, agreement could be studied for joint ventures or more regular boundary spanning relationships. Within firms, a multidimensional view of agreement could be applied to top management teams (Dess, 1987) or internal venture activities (Shortell and Zajac, 1988).

Acquisition integration

A finding of prior studies has been that preacquisition activities are poorly connected to postacquisition efforts. The thrust of many studies has been on how the well-intentioned plans of acquirers tend to go awry (Scherer, 1986; Porter, 1987; Haspeslagh and Jemison, 1991). Few studies have collected systematic data on the *interaction* of acquired and acquiring firms during integration. This study has analyzed both sides of an acquisition, using relational data, and has focused on issues of decision maker agreement on key objectives. Our results on agreement and the intergroup context in which it occurs help clarify why this disjunction between pre and postacquisition occurs.

That actual agreement is negatively associated with success expectations suggests that an emphasis on agreement during integration may be counterproductive. If one considers economic theories of acquisition, this makes sense. If the synergies required for a viable acquisition are real, they imply major differences between firms, differences that are complementary. Prescriptions regarding related diversification strategies recommend that acquirers have something in common with acquired firms upon which value can be created (Salter and Weinhold, 1979; Harrison, et al., 1991).

In a very important sense, however, a viable strategy of related diversification also requires that a firm should acquire what it does not already have—that acquired and acquiring firms should be different on some dimensions if value is to be created. However, studies of integration note that acquirers often use assumptions of homogeneity to guide their integration behaviors. The problem with using such assumptions is that by integrating with the intent of bringing about homogeneity, the acquirer may end up destroying the differences that made the acquisition desirable in the first place.

Even if agreement is desirable, it may not be easily attainable by information programs or

process changes. That involvement is not associated with actual agreement suggests that increased contact is not the answer. It is unreasonable to think that it would be if basic differences exist between firms. Such suggestions for increased contact, however, are frequently made in prescriptions for integration (McCann and Gilkey, 1988).

Intergroup theory may provide a logic for the difficulties experienced by acquirers with integration. The need for a mechanism to explain postacquisition activities has been mentioned by other researchers (Walsh, 1988). That perceived agreement is inversely associated with internal agreement suggests that the need to reaffirm social identities disrupted by acquisition leads decision makers in both the acquired and acquiring firms to behave in ways that destroy rather than create value. This is supported by the results for involvement in integration decisions. This study is not alone in suggesting the importance of intergroup dynamics for acquisitions (Haspeslagh and Jemison, 1991). It has developed agreement and intergroup ideas in greater detail for acquisitions. Future research can extend this work to other types of acquisitions and to such related activities as mergers, internal consolidations, and joint ventures.

Limitations

These results reflect two hospitals at one point in their integration. The potential for generalizing from these results is limited, since alternate explanations concerning the idiosyncracies of these organizations cannot be ruled out. Such generalizability was not intended. Our case approach is intended to discipline our inquiry into this case and help show how agreement can be studied in specific situations (Yin, 1989). Generalization must come from other studies.

It would have been valuable to survey the decision makers in both organizations at the time the combination was announced and such an effort seemed possible, given that access was obtained promptly and that this was basically a friendly combination. However, the difficulties in surfacing the actual objectives of all the parties to this combination, in conjunction with the conflicts that emerged in this initially cooperative combination, delayed an initial survey effort since it would have materially worsened conditions between the two organizations.

It would have been useful to augment these results with a resurveying of the population. In the year following data collection, however, changes in the markets faced by these hospitals occurred, including closures, service reductions, attempts at mergers, and entry by a national chain. The performance of these hospitals, as well as the attitudes of their managers, were influenced by these changes. The problems of separating out these competing explanations made the benefits from such a resurveying effort limited relative to the costs.

This problem was apparent on the issue of physician exits from the acquired hospital. Given the conflicts and goal disagreements of this acquisition, one would expect that dissatisfied physicians in the acquired hospital who could move their practices elsewhere would do so. Such exits would have increased the hospital's deficit and worsened performance. While it was apparent from interviews that many physicians wanted to leave, few did so because the local environment was sufficiently turbulent to make the move to another hospital quite risky. Constraints on physician mobility moderated the effects of disagreement over what they would have been at the initial time of combination.

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APPENDIX 1: CORRELATIONS OF RATINGS OF ACQUISITION OBJECTIVES

Objective	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14
1. New doctors	0.60	0.58	0.56	0.11	0.63	0.50	0.59	0.62	0.47	0.54	0.21	0.42	0.44
2. Medical education		0.39	0.24	−0.05	0.49	0.39	0.43	0.50	0.39	0.32	0.01	0.43	0.37
3. Financial performance			0.49	0.03	0.52	0.46	0.57	0.48	0.47	0.49	0.16	0.43	0.44
4. Building practices				0.53	0.49	0.37	0.42	0.48	0.31	0.48	0.36	0.29	0.33
5. New markets					0.11	0.15	0.08	0.01	0.08	0.24	0.43	0.00	0.16
6. Quality care						0.68	0.68	0.71	0.47	0.50	0.16	0.43	0.42
7. Reputation							0.51	0.64	0.36	0.41	0.29	0.43	0.49
8. Research								0.62	0.57	0.45	0.19	0.38	0.41
9. Expertise									0.48	0.36	0.23	0.38	0.39
10. Sharing services										0.64	0.03	0.29	0.41
11. Third parties											0.33	0.30	0.38
12. Referrals												0.21	0.33
13. Heart program													0.75
14. Cancer program													

Correlations greater than 0.15 are significant at $p \leq 0.1$
Correlations greater than 0.19 are significant at $p \leq 0.05$
Correlations greater than 0.26 are significant at $p \leq 0.01$

APPENDIX 2A: OWN RATINGS OF OBJECTIVES (BY HOSPITAL)

	Acquired hospital		Acquiring hospital		
Variable	Mean	S.D.	Mean	S.D.	*p*
New doctors	8.95	1.38	4.47	2.95	0.00
Medical education	7.56	2.01	4.58	2.40	0.00
Financial performance	9.49	0.85	6.52	2.63	0.00
Building practices	8.67	1.59	6.95	2.06	0.00
New markets	7.37	2.42	8.32	2.30	0.07
Quality care	7.20	2.87	2.98	2.36	0.00
Heart program	9.44	1.57	7.76	1.91	0.00
Cancer program	8.54	1.88	7.21	2.23	0.01
Referrals	6.59	2.97	6.61	2.70	0.97
Reputation	8.51	1.94	5.19	2.91	0.00
Research	7.08	2.36	3.19	2.47	0.00
Sharing expertise	7.64	2.25	3.32	2.45	0.00
Sharing services	7.50	2.06	5.95	2.48	0.00
Third parties	7.55	2.62	6.44	2.78	0.07

APPENDIX 2B: 'OTHER' RATINGS OF OBJECTIVES (BY HOSPITAL)

	Acquired hospital		Acquiring hospital		
Variable	Mean	S.D.	Mean	S.D.	*p*
New doctors	5.38	2.88	8.20	1.99	0.00
Medical education	5.10	2.69	7.00	2.63	0.00
Financial performance	7.00	2.60	8.64	1.96	0.00
Building practices	6.03	2.53	7.37	2.37	0.01
New markets	8.50	1.69	4.58	2.72	0.00
Quality care	5.38	3.13	6.25	2.34	0.16
Heart program	7.32	2.78	8.79	1.36	0.00
Cancer program	7.71	2.30	8.64	1.09	0.03
Referrals	7.82	2.23	5.98	2.87	0.00
Reputation	5.79	3.42	8.44	1.61	0.00
Research	4.82	3.27	5.48	2.93	0.34
Sharing expertise	4.41	3.01	7.25	2.00	0.00
Sharing services	5.74	2.73	6.77	2.26	0.07
Third parties	6.21	3.09	6.19	2.92	0.97