2011

The Roles that Change in the Controls and the Evolution of Trust Play in a Successful Joint Venture

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The Roles that Change in Controls and the Evolution of Trust Play in a Successful Joint Venture.

A DISSERTATION

SUBMITTED TO THE FACULTY OF THE SCHOOL OF EDUCATION

OF THE UNIVERSITY OF ST. THOMAS

By

Michael James Willis

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF EDUCATION

April 2011

UNIVERSITY OF ST. THOMAS

We certify that we have read this dissertation and approved it as adequate in scope and quality. We have found that it is complete and satisfactory in all respects, and that any and all revisions required by the final examining committee have been made.

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Acknowledgments

While researching and writing a dissertation over the past two years has primarily been solitary endeavor, I have several people to thank. I could not have conducted or completed this research without their help.

First, I want to thank the people of Restorative Health, Central Health Care, Atlas Group, and Great Plains University. The physicians, administrators, and executives of these organizations opened up their schedules, allowed me to interview them, and openly and honestly shared their feelings and experiences that transpired over the first five years of the joint venture.

Secondly, I am grateful for Megan Rounds for the use of her transcription software and equipment, for Liz Knight for her accuracy and expertise in transcribing my interviews, and for Janet Webster for introducing me to some of the participants in my research study.

Third, I appreciate the time and interest given by Drs. Gregg Taragos, John Conbere, and Rama Hart who served as my dissertation committee over the past eighteen months. Their expertise in research methodology and joint ventures was a great asset. In particular, I want to thank Rama who served as my dissertation Chair and for working closely with careful review feedback on my proposal and dissertation

Fourth, I wish to express gratitude to my family: my daughters Jessica and Lauren, and especially Dana, my wife. During the last two summers, we spent a week on the North Shore of Lake Superior and in Nauvoo, Illinois away from home so I could focus on writing. Dana's support and encouragement through the entire Doctoral experience has been unfailing and unending. I have faith that the sacrifices we made together in time, money, and sleep will somehow be returned to us.

Finally, the completion of my dissertation may not appear to others to be as significant or timeless as George Handel's masterpiece *The Messiah.* However, I wish to echo Handel's explanation that "God visited me" and acknowledge and thank my Heavenly Father for helping me to undertake and complete this research study and degree.

Abstract

The purpose of this study was to explore the roles that changes in formal and informal controls play in the evolution of trust over the lifecycle of a successful joint venture. While leaders often form joint ventures to manage risk and uncertainty and gain a competitive advantage in the market place, forming a joint venture presents a new set of risk and uncertainty to be managed with partner organizations. Because trust generally does not previously exist among organizations that form a joint venture, leaders may use formal and informal controls to shape attitudes and behaviors towards desired goals and outcomes (Gulati & Nickerson, 2008). In this study, I sought to better understand how the uses of controls change and how trust evolved over the lifecycle of a successful joint venture.

To gain this knowledge, I conducted an interpretive case study of a joint venture formed by three health care organizations in the Midwest United States. Results from interviews with executive administrators, department administrators, and physicians of all three parties resulted in identification of the following formal and informal controls.

Formal controls: financial reward system, organizational structure, and selection and placement of people

Informal controls: compelling vision/mission, relationships, and buy-in/support

These controls had both a positive and negative impact on the evolution of trust over the lifecycle of the joint venture. Leaders made adjustments to formal controls over the lifecycle that resulted in an overall positive impact on trust. While trust changed as relationships changed, trust did not change as the compelling vision/mission and buy-in/support remained strong and steady over the lifecycle of the joint venture.

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Chapter One

Strategic alliances are relationships between two or more firms that unite to pursue a set of common goals, while remaining independent subsequent to the formation of the relationship. These firms share the benefits of the alliance and control over the performance of the assigned tasks and continue to make contributions in at least one key strategic area to the alliance (Yoshino & Rangan, 1995). As such, strategic alliances are one approach that leaders use to gain a competitive advantage (Ring & Van de Ven, 1994).

Joint venture, minority equity, and non-equity are three types of strategic alliances. In a joint venture, entities are independently incorporated and separate from, but jointly run, by parent firms (Yoshino & Rangan, 1995). Organizations frequently form joint ventures when tasks between firms need to be highly integrated and when the alliance business will be characterized by uncertainty and decision-making (Doz & Hamel, 1998). Generally, joint ventures with a fifty-fifty arrangement are complex and require a high degree of collaboration and cooperation. This type of alliance requires leaders and individuals within the firms to work together closely to make decisions, resolve conflicts, and establish strong commitment.

Through alliances, organizations can share costs, risks, production facilities, and technology. Other benefits include allowing partner firms to gain access to financial resources, new markets, and new products (Provan & Kenis, 2008). In addition, the firms can leverage key differences including customers, knowledge, processes and culture (Hughes & Weiss, 2007; Nohria & Eccles 1992).

However, while alliances can bring great rewards to organizations, they also carry high rates of failure. According to Dyer, Kale, and Singh (2001), almost half of the strategic alliances fail. Hughes and Weiss (2007) report that while the rate of organizations that form alliances

increases by about 25% per year, the rate of failure for alliances runs as high as 60% to 70%. In addition, research that compares strategic alliances with formal organizations shows that alliances are less stable and less successful (Das & Teng, 2000). These startling statistics should cause leaders and Organization Development (OD) practitioners to ask why the success rate for alliances is so low and what can be done to improve the rate of success.

Alliances Involve Risk and Uncertainty

Mitigating risk and uncertainty are two reasons that organizations join alliances; they are also two key forces that can contribute to the success or failure of an alliance. In trade and research publications, alliances are frequently compared to a marriage relationship (Kanter, 1994, Kemeny & Yanowitz, 2000). As such, these authors describe how the success or failure of both types of relationships is determined by the two parties' ability to recognize that they must learn to work together and that their success is tied to each other. Thus, whether the marriage consists of two individuals or two organizations moving from a traditional arms-length relationship to a collaborative and interdependent relationship, both involve a high degree of risk and uncertainty (Ertell, 2001).

Performance risk and relational risk are two types of risk that exist when firms form an alliance. Performance risk is the risk that firms will not be able to reach their goals despite cooperation between the firms (Das & Teng, 1998). In contrast, relational risk is the risk that firms will not be able to cooperate or that one firm will act in an opportunistic manner and take advantage of the other firm (Das & Teng, 1998).

While both types of risk contribute to the success or failure of an alliance, many researchers conclude that relational risk, also referred to as the human factor – how people think and act together - plays a more dominant role in the success or failure or an alliance (Kemeny &

Yanowitz, 2000). Based on experience working with clients from hundreds of failed alliances, Hughes and Weiss (2007) stated that business planning was rarely cited as a cause of the alliance failure. Instead, clients consistently pointed to "breakdowns in trust and communication and the inability to resolve an inevitable succession of disagreements as the most common causes of failure" (p. 123). Das and Teng (1998) also cite a lack of cooperation and opportunistic behavior by one alliance partner that unfairly benefit one partner over the other partner as causes for the high rate of alliance failure. Thus, while the knowledge and skills to build strong relationships with partner firms are important, current efforts fall short.

Controls Help to Manage Risks

Establishing controls is a common practice by firms within an alliance to create predictability, stability, and to manage and mitigate relational risk. Controls help firms regulate the behavior of alliance members and govern and structure the relationship to meet objectives of the alliance and its partners (Costa & Bijlsma-Frankema, 2007). Controls can be formal or informal and provide structure, define behaviors, and minimize risk.

Formal controls. According to Inkpen and Currall (2004), formal controls tend to be predictable, regular, involve the explicit transfer of information, and codified in rules, procedures, and regulations. Examples of formal controls include formal contracts, rules, regular meetings between parent and alliance managers, and policies and procedures created and implemented to monitor and reward desirable performance (Inkpen & Currall, 2004; Das & Teng, 2001).

Informal controls. Informal controls, also known as social controls, are more uncertain, ambiguous, and organizationally embedded (Deakin & Wilkinson, 1998). Informal controls use values, norms, and cultures to encourage and shape desirable behavior (Das & Teng, 1998).

Examples of informal controls include socialization, training, and spontaneous interactions between partners and personal friendships between managers (Das & Teng, 1998; Doz, 1996).

Role of Trust

While formal and informal controls are valuable in an alliance because they help to make behavior more predictable and align that behavior with the objectives of the alliance, trust between alliance partners is a third important dynamic in this phenomenon.

Trust is the belief that each partner in the alliance will act in good faith and uphold their commitments in situations that involve an element of risk (Das & Teng, 1998). Thus, risk is found at the core of trust because only in situations of uncertainty and risk will trust be a relevant factor. In addition, trust will exist in alliances in some degree because firms have to take risks, rely on their partners' performance, and become vulnerable to their partners' actions (Das & Teng, 1998; Kumar 1996).

When a firm trusts their alliance partner, coordination will be facilitated, transaction costs will be reduced, and risk and the need for controls will be reduced (Gulati & Nickerson, 2008). However, trust is not automatically available in alliances, and trust must be earned unless firms have previously worked together or unless one of the partners has a very strong reputation (Doz & Hamel, 1998). Thus, trust is built over time through a collaborative process (Doz & Hamel, 1998). This phenomenon of how trust evolves, combined with the dynamics of how controls change, requires insight and perspectives of the people who lead and implement alliances.

Purpose of This Study

The high rates of failure in strategic alliances underscore the fact that organizations value and continue to attempt to form and launch alliances, even though there are many things they do not yet fully understand about how to design and implement alliances. Thus, there is a critical

need and opportunity to learn more about what leads to success in alliances and how to replicate this success. The purpose of this study was to gain insights and understanding into the factors that lead to successful alliances. Specifically, I focused on the following research questions:

RQ1: What roles do formal controls play in influencing the establishment of trust during each stage of the lifecycle of a joint venture?

RQ2: What roles do informal controls play in influencing the evolution of trust during each stage of the lifecycle of a joint venture?

RQ3: How do leaders experience trust during each stage of the lifecycle in a joint venture?

RQ4: What is the process to build trust within the joint venture?

Significance of the Study for the Business Leader

This study is significant because new insight and knowledge into design and implementation of successful alliances will provide leaders with four benefits: increased cost savings, greater flexibility, increased knowledge of how to bring systems together, and greater support for middle and front-line managers. These benefits are described further in the section below.

Cost savings. A higher success rate of alliances can translate into cost savings. As trust develops and fear of opportunism fades between partners, the costs of formal coordination and monitoring may decrease which will increase the efficiency of the collaboration (Inkpen & Currall, 2004).

Need for flexibility. Alliances are not static, but are constantly in a state of change and evolution. As a result, the alliance will often evolve in ways the partners did not predict when the alliance was formed (Bamford, Gomes-Casseres, & Robinson, 2003). Also, the alliance will

change from the time when the partners first met and negotiated the agreement through the implementation of the alliance. Thus, this study will provide greater understanding into the factors that influence trust and controls and help leaders prepare for and lead their alliance in a more flexible manner.

Need for new knowledge to bring systems together. This study is significant because leaders often lack the expertise to bring new systems together. Before forming an alliance, leaders generally have already experienced success at mastering task efficiency, functional excellence, and even cross-functional excellence in their own organization. As a result, crossing organizational boundaries and aligning two independent organizations to reach joint goals can be seen as a natural next step. However, while many of the same experiences and issues found in achieving cross-functional excellence can apply to achieving cross-organizational excellence, the difficulties are exponentially larger because leaders are working to coordinate and optimize a new and larger system (Kemeny & Yanowitz, 2000).

Middle and front-line managers need greater support. Middle and front line leaders need more insight and guidance from senior leaders on how to successfully build relationships and implement alliances. According to Kanter (1994), top executives too often

> . . . devote more time to screening potential partners in financial terms than to managing the partnership in human terms. They tout the future benefits of the alliance to their shareholders but don't help their managers create those benefits. They worry more about controlling the relationship than about nurturing it. In short, they fail to develop their company's collaborative advantage and thereby neglect a key resource. (p. 96)

Thus, this study will provide new insights for middle and front-line leaders and help leaders overcome situations where their senior leaders are more focused on the financial terms and future benefits to shareholders and less concerned about how their managers can create and achieve these benefits (Kanter, 1994).

Significance of Study for the OD Practitioner

As an OD practitioner, I first became interested in joint ventures two years who while studying and leading a project at my employer on how networks form and evolve among individuals in organizations. During this time, I was drawn to how organizations form networks and how trust evolves between the partner organizations. I learned that firms join alliances because they want to leverage differences that other firms offer. These differences can include different processes, technology, and resources. However, these differences often include differences in goals, norms, perceptions, and priorities, and these differences can present a significant challenge for leaders to integrate the two organizations and to create alignment among individuals and groups (Kemeny & Yanowitz, 2000). In addition, the more numerous and vast the differences that partner firms bring to the alliance, the greater the challenge for leaders to bring the new system together (Kemeny & Yanowitz, 2000).

This study will be significant for OD practitioners because they play a critical role in helping to facilitate and guide leaders through the change process as alliance partners leave their former identities as independent organizations and form a new and united identity. In addition, OD practitioners will gain insights into the mental models in the form of norms, perceptions, and priorities that leaders and firms bring to the alliance and how the OD practitioner can help them form new norms, goals, and perceptions to serve as informal controls and help trust grow and evolve.

Significance of Study for Researcher of Strategic Alliances

Besides benefiting the business leader and OD practitioner, this study will also make significant contributions to researchers of strategic alliances. In order to study how changes in controls impact the evolution of trust in a three-party health care strategic alliance in the

Midwest, I will use an interpretive case study methodology. Besides being an underused methodology, this research design will make two main contributions to researchers of alliances. First, the case study methodology will allow me to gather thick and rich descriptions of leaders' experiences over the lifecycle of the alliance. Second, my research will advance understanding of the process of alliances and the roles of formal and informal controls in building trust over the lifecycle through a field-based exploration of the phenomenon of an alliance and through the narrative of the people who helped develop and work within the alliance.

Plan for Dissertation Chapters

Within the following eight chapters, I will review literature, outline my methodology to conduct research, and describe the results and meaning of the results. In Chapter 2, I review relevant literature that examines how trust, risk, and controls influence each other within joint ventures. This literature includes theoretical frameworks, empirical studies, and interpretive studies. I describe my case study methodology to conduct the research in Chapter 3.

In Chapter 4, I describe the lifecycle and the eight stages the evolved over a five-year span at the joint venture. In Chapters 5 and 6, I describe the results that changes in formal and informal controls played in the joint venture. While strong trust developed among leaders, distrust also evolved with some individuals and leaders of the different partner organizations. I describe how trust changed over the lifecycle in Chapter 7. After describing the results of the research in three chapters, I will synthesize both the literature and the results of the case study to describe meaning and potential implications in Chapter 8. This chapter will also include recommendations for future research.

Chapter Two

REVIEW OF THE LITERATURE

The purpose of the following section is to establish a conceptual framework and cite appropriate areas of research and thinking from different perspectives (McMillian, 2004). The following section also introduces meaningful analogies and perspectives from scholarship to conceptually frame some very general and broad questions to be explored (McMillian, 2004). These questions provide a general direction and purpose for the study so that previous work will not limit, constrain, or predict what this research study will find (McMillian, 2004); rather, in this literature review, I inductively discovered new insights and generate a deeper understanding of strategic alliances.

Lifecycle of Alliances

Like most living things, strategic alliances often follow natural lifecycles. Kanter (1994) and Ring and Van de Ven (1993) described similar, but different stages through which alliances pass. According to Kanter (1994), no two alliance relationships travel the exact same path, but successful alliances generally follow five overlapping phases.

Kanter Lifecycle

Kanter (1994) led a research team that observed 37 companies and their partners from 11 parts of the world in a wide range of industries and alliances. From this research, she concluded that alliances pass through five phases: "selection and courtship, getting engaged, setting up housekeeping, learning to collaborate, and changing within" (p. 99).

In the selection and courtship phase, two firms meet, are attracted, and discover their compatibility. During the engagement phase, the two firms draw up plans and close the alliance deal. In the third stage, similar to newly wedded couples, firms set up housekeeping rules as

they discover they have different ideas about how the alliance should operate. During phase four, individuals in the alliance devise mechanisms to bridge these differences and develop techniques to get along. By the fifth and last stage, individuals in the alliance think and act as an old-married couple and discover that they have changed internally as a result of making accommodations through the ongoing collaborative relationship of the alliance (Kanter 1994).

Ring and Van de Ven Lifecycle

While Kanter uses the marriage analogy and described an alliance lifecycle as sequential, Ring and Van de Ven compare an alliance to an evolving partnership that follows an iterative process. Ring and Van de Ven (1994) defined inter-organizational relationships to include groups such as franchises and coalitions that are outside of the definition of strategic alliances applied in this study, and aspects of their model of the developmental process are particularly useful in understanding how inter-organizational relationships evolve.

According to Ring and Van de Ven (1994), inter-organizational relationships pass through stages of negotiation, commitment, and execution. Within each stage, individuals in the relationship make assessments based on the efficiency and equity of the relationship and whether to continue or discontinue the relationship.

Negotiation. In the negotiation stage, firms conduct due diligence and "develop joint expectations about their motivations, possible investments, and perceived uncertainties of a business deal that they are exploring to undertake jointly" (Ring & Van de Ven, 1994, p. 97). Together, the firms "select, approach, or avoid alternative parties as they persuade, argue, and haggle over possible terms and procedures of a potential relationship" (Ring & Van de Ven, 1994, p. 97).

While these firms would normally work independently, they consider forming a partnership as they participate in two processes simultaneously. They work through a formal bargaining process and a social-psychological process of sense making. Through repeated efforts and interactions at both formal bargaining and informal sense making, the firms assess

> . . . uncertainty associated with the deal, the nature of each other's role, the other's trustworthiness, their rights and duties in the transaction being considered and possible efficiencies and equity of the transaction as it relates to all parties. (Ring & Van de Ven, 1994, p. 98)

Firms complete the negotiation stage with a joint-agreement to form a partnership.

Commitment. During the commitment stage, the firms continue with another iteration of discussion with the focus on reaching consensus on obligations and rules for future action in the relationship. Representatives of the firms discuss and agree on terms and governance structure of the relationship. The terms and structure of the partnership will be codified in a formal relationship contract or informally understood in a psychological contract between the firms. Similar to the process used in the negotiation stage, a series of interactions is often necessary for the firms to work through issues and reach lawful and mutual consent (Ring & Van de Ven, 1994).

Generally, firms complete the commitment stage with a formal contract. However, some partnerships may reach agreement on their commitments with a handshake, depending on the level of business risk and the level of trust between the firms. To avoid legal obstacles, such as "mistake, misrepresentation, undue influence, or duress which would otherwise rend the relationship null and void," some firms involve legal agents when the formal contract is written during the commitment stage (Ring & Van de Ven, 1994, p. 98).

Execution. During the execution stage, firms within the new partnership carry out commitments and rules of action as agreed upon. The partnership is now operating as one unit

and the firms give directives to their employees such as to acquire materials, pay the amounts agreed upon, and execute other tasks in order to implement the partnership agreement. During this stage, behavior by people in formally designated roles initially helps to reduce uncertainty as commitments are executed and interactions between people in the partnership become more predictable (Ring & Van de Ven, 1994). This decrease in uncertainty and increase in predictable behavior comes through a series of role interactions where people are able to become more familiar with each other as they increasingly rely less on inter-role relationships and more on interpersonal relationships (Ring & Van de Ven, 1994).

Relevance of Ring and Van de Ven's Model to Current Research Study

According to Ring and Van de Ven's (1994) model, before formally moving to the next stage of the lifecycle, the parties in the partnership make an assessment of the commitments they made. If commitments were executed in an efficient and equitable manner, they will continue with or expand their mutual commitments. If not, the parties initiate corrective actions by either renegotiating or reducing their commitments within the partnership (Ring & Van de Ven, 1994).

I am intrigued by this assessment and evaluation process that parties go through before they move on to the next stage of the lifecycle. I believe there may be other important questions and decisions that parties ask and make that are common to all stages of the lifecycle before they move forward with their partnership. Ring and Van de Ven (1994) supported this notion by stating:

> Underlying these heuristics is a more complicated set of informal social-psychological dynamics that go on and that explain how and why cooperative IOR (inter-organizational relationships) evolve through repetitive sequences of formal negotiation, commitment, and execution stages or events. (p. 99)

This concept will be outlined and explored in the remaining section of the review of the literature.

Alliances Involve Continuous Monitoring and Learning

When launching an alliance, leaders initiate dynamic relationships. As such, these relationships must evolve as they pass through a number of transitions in order to be successful (Doz, 1996). One of the ways these relationships evolve is when alliance partners watch and learn about each other. Through this process, the initial conditions of the alliance can start to evolve as mutual learning takes place and "partners increase their understanding of each others' complementary contributions, competitive positions, strengths and weaknesses, culture, and strategic objectives" (Inkpen & Currall, 2004, p. 592).

Also, trust, controls, and relationships are not static, but influence each other and change as the alliance passes through the different stages of its lifecycle. Thus, the phenomena of how controls change and trust and relationships evolve should be studied from a systems level and not just by looking at one specific stage. The following section further defines trust and controls, outlines some factors that have been found to influence a change in trust and controls, and lists questions that need to be explored to better understand the phenomena that leads to successful alliances.

Trust

Up to this point in the study of trust and controls, trust has been described as a desirable outcome and a key element of a strategic alliance. Two types of trust exist in alliances: goodwill trust and competence trust.

Goodwill Trust

Goodwill trust is related to relational risk and represents the expectation and perception that that a partner will fulfill their commitment and role in the alliance. Goodwill trust is based on the mutual perceptions that the partner will not act in an opportunistic manner that would take unfair advantage of the other partner or create unequal benefits for one partner. Goodwill trust allows firms to cooperate in good faith and can act as a substitute for formal controls as trust reduces the need to design and monitor contractual safeguards (Costa & Bijlsma-Frankema, 2007).

Competence Trust

Competence trust is the ability for a partner to do the right things in the alliance. Competence trust reduces performance risk and the expectation that partners have the ability to fulfill their roles (Das & Teng, 2001). While both types of trust are important, goodwill trust plays a more important role in an alliance relationship because some degree of goodwill trust is required for partners to take the first steps to work together. For the remainder of this study, goodwill trust will be referred to as "trust."

Initial Forms of Trust in Alliances

When an alliance is first formed, trust cannot be generated instantaneously between firms that do not already have a previous relationship working together. Instead, trust must develop incrementally and be built by developing bonds or shared norms and values (Nooteboom et al., 1997). Trust starts initially when people in a firm show trust in their partner in a small way and observe the consequences. The firm will be likely to extend more trust if its partner firm behaved in a trustworthy manner (Inkpen & Currall, 2004). In addition, Powell (1996) argued that trust is a product of ongoing interaction and discussion that must be learned and reinforced.

Yet, during the early stages of an alliance, potential partners are often suspicious of each other and unsure of the value that could come from the alliance (Doz & Hamel, 1998). Thus, while trust starts from small and successful interactions, controls can help provide some reassurance that their partner firms will act in a trustworthy manner. Through an interpretive study of leaders' experiences over the lifecycle of the strategic alliance, I hope to provide a deeper and richer understanding and description of how leaders experience trust over the stages of the alliance, how the use of formal controls and informal controls change over these stages, and the process to built trust within the strategic alliance.

Formal Controls as Factors to Increase Trust

While firms may already have some level of confidence in the trustworthiness of the other joint venture partner, they are wary to rely exclusively on this trust. Thus, the ability for firms to rely on trust at an interpersonal level may be conditional upon legal systems or organizational role responsibilities that would mitigate the ability of the parties to rely on trust as a matter of first preference (Ring & Van de Ven, 1994).

Benefits of Formal Contracts

The contract is a form of legal regulation and serves as an important precondition to establish trust when firms work together collaboratively (Costa & Bijlsma-Frankema, 2007). There are several benefits to using legal contracts as a form of formal control in alliances.

Contracts provide lifejackets. In lieu of an exclusive reliance on trust, firms write formalized contracts and other documents to serve as "exogenous safeguards" and "lifejackets" to help people deal with the uncertainties faced in a partnership (Ring & Van de Ven, 1994, p. 96). Under these conditions, managers will be more likely to trust managers of the other firm

when they know that structural safeguards exist at the firm level and less focused on self-protection (Sitkin, 1995; Inkpen & Currall, 2004).

Contracts facilitate learning. According to Sitkin (1995), as firms work together through the process of crafting a mutually agreeable set of documents, they will gain understanding of each other's perspective. Through the process of writing a contract, firms are able to interact with greater transparency and collaboratively identify objectives for the partnership (Inkpen & Currall, 2004).

Contracts create stability. A formal contract helps to make behavior of the firms more predictable by establishing objective rules and clear measures that will help create a "track record" for people to base their assessments and evaluations of others. Also, a formal contract defines the responsibilities of the firms by defining formal rules, procedures, and policies to monitor and reward desirable performance in the partnership (Das & Teng, 2001). These formal controls make the transfer of information predictable, regular, and explicit and allow inputs, outcomes, and inter-organizational activities to be codified and enforced (Das & Teng, 2001; Costa & Bijlsma-Frankema, 2007).

Contracts help to coordinate activities. The formal contract provides not only a means of control, but also a coordinating function. The contract helps to coordinate the alignment of activities, decompose tasks, establish and communicate activities, and serve as a technical aid to manage relationships (Vlaar et al., 2007).

Limits to Formal Contracts

While contracts are valuable in reducing uncertainty, coordinating activities, and establishing trust, contracts can also have negative impacts. For example, contracts can signal distrust, undermine the development of relationships between firms, and encourage opportunistic

behavior (Gulati & Nickerson, 2008). Also, contracts with high levels of formal coordination and control can negatively impact organizational performance if individuals feel the contract is cumbersome, over-regulated, and if they feel the contract contains impersonal processes that they are forced to follow (Beck & Kieser, 2004).

Finally, contracts that are excessively formal can lead to conflict and disagreement among firms and have a retarding effect on creativity and innovation and inhibit the flexibility that is needed to cope with complex, ambiguous, and task environments (Vlaar et al., 2007). Thus, formal contracts should provide enough detail to identify key objectives and roles of the partnership, but should not be overly detailed in order to allow trust to continue to grow and evolve between the two firms. With a foundational understanding of benefits and limits to formal controls, research has not yet been conducted on how formal controls change over the negotiation, commitment, and execution stages of the alliance. Through my interpretive research design and analysis, I was gain rich and thick details and anticipate a greater understanding of how formal controls influence the establishment of trust and change over the lifecycle of the strategic alliance.

Informal Controls as Factors to Increase Trust

While formal contracts identify the formal controls and rules of the partnership, informal controls will also need to be established to structure and govern the alliance. These informal controls are the values, norms, and culture that will either be a blend from the two firms or completely new values, norms, and culture that the firms want to create.

Informal Controls Build Internal Relationships and Infrastructure

From her research, Kanter (1994) found that while individuals in the alliance cannot be "controlled" by formal systems, they require a dense web of interpersonal connections and

internal infrastructures to enhance their learning. This reference to interpersonal connections and internal infrastructures aligns with the goals of informal controls: to build relationships between individuals in the alliance so that norms, values, culture, and trust can develop and direct people to the goals of the alliance.

Informal Controls Help Firms Work through Differences

While the diversity of the partner firms may have initially attracted the firms to join together, the differences can also reduce the fit of the firms and create difficulties in managing the partnership. Thus, setting up norms and mechanisms to "address joint-decision making, introduce new routines, communication protocols, reporting and approval procedures" can take time and require partners to incur costs (White, 2005, p. 1389)**.**

These informal controls are just as important to the development of trust as formal controls. As described earlier, trust helps to reduce risk and uncertainty. However, trust cannot be achieved instantaneously. If trust does not already exist between the two firms, it will need to be built by developing bonds or shared norms and values (Nooteboom, 1997).

According to Das and Teng (1998), firms that are successful in managing alliances use both formal and informal controls to ensure that their goals are achieved. Yet, since informal controls rely on leaders blending culture and shared values, reliance on formal controls may be the only option when the partnership is first formed.

Levels of Controls Change Over time

As the firms in the partnership become more confident in their ability to structure and manage the governance process, a shift away from formal controls to more flexible informal controls may result. Thus, as the interface between the firms evolves and as common values and

norms emerge, informal controls can complement formal controls and in some cases, informal controls may be more efficient than formal controls (Inkpen & Currall, 2004).

Roles of Joint Decision Making and Conflict Resolution in Increasing Trust

The potential for conflict and disagreement while working together and making joint decisions is natural and common in alliances. This is especially true for firms during the early stage of an alliance when trust does not yet exist. Reaching agreement on control mechanisms is likely to be one of the most challenging decisions firms will need to make together.

This difficulty in reaching agreement comes as part of the nature of the alliance. Partners, often with disparate skills and objectives, pool a portion of their resources to form a new entity. Yet, at a time when firms need to work together closely, it is also a time when they are they are poorly positioned to cooperate (Doz & Hamel, 1998).

Learning As a Factor to Increase Trust

Learning has been cited as a key contributor to the evolution of trust and change in formal and informal controls. According to Doz (1996), learning processes are central to the evolution of a joint venture. Doz (1996) examines learning in joint ventures from two perspectives:

1. Learning about the joint venture partner. This type of learning is primarily endogenous to the collaboration. This type of learning is important in order to for firms to combine their skills successfully in the alliance. Learning about a partner facilitates relational understanding and can provide the foundation of trust development with trust constituting the currency by which joint venture knowledge gets acquired and traded by joint venture partners (Inkpen & Currall, 2004).

2. Learning from the joint venture partner. This refers to skill familiarity and skill mastery. This type of learning is more transactional in nature and can increase partner bargaining power and reduce dependence, which may lead to instability and reduced trust for the "teaching" partner (Inkpen & Currall, 2004).

The significance of learning is that as joint venture partners acquire knowledge that is useful in the design and governance of the alliance, uncertainty may be reduced, which may lead to a greater willingness to trust a partner. As a leaders and people in the alliance become more confident in their ability to structure and manage the alliance governance process, the partners may shift away from formal controls to more flexible social controls. Thus, a partner firm's willingness to de-emphasize formal control could be the result of a combination of learning about the partner and learning about alliance governance (Inkpen & Currall, 2004). As with the informal controls components of Inkpen and Currall's (2004) conceptual framework, I also applied my interpretive and field-based exploration to this phenomenon to better understand how learning influences the evolution of trust and changes in formal and informal controls.

State of Recent Research

Up to this point in Chapter 2, I have reviewed foundational research by Ring and Van de Ven (1994) and Kanter (1994) on different lifecycle models and reviewed literature on elements that influence each other over the lifecycle, such as relationships (Doz, 1996; Inkpen & Currall, 2004) ,trust (Costa & Bijlsma-Frankema, 2007; Das & Teng, 2001), Nooteboom et al, 1997; Inkpen & Currall, 2004; Powell, 1996; Doz & Hamel, 1998); formal controls (Ring & Van de Ven, 1994; Sitkin, 1995; Inkpen & Currall, 2004); informal controls (White, 2005; Nooteboom, 1997; Das & Teng, 1998; Inkpen & Currall, 2004), decision making (Doz & Hamel, 1998), and

learning (Doz, 1996; Inkpen & Currall, 2004). These studies and other relevant research are summarized in Table 1.

Table 1
Summary of Key Studies on Strategic Alliances

Author	Method	Sample	Results
Ring & Van de Ven (1994)	Theory building	N/A	Proposed framework that focused on formal, legal, and informal social psychological processes used by parties to jointly negotiate, commit to, and execute their relationships.
Das & Teng (1998)	Theory building	N/A	Proposed model on how trust and control are parallel concepts and their relationship supplements the generation of confidence
Das & Teng (2001)	Theory building	N/A	Proposed comprehensive and integrated framework of trust, control, and risk in strategic alliances.
Inkpen & Currall (2004)	Theory building	N/A	Propose framework to explain how initial joint venture conditions give way to evolved conditions as joint venture partners develop an understanding of each other and adjust the collaborative process.
Adobor (2006)	Theory building	N/A	Proposed strategies to manage downside of personal relationships over the lifecycle of alliances.
Vlaar, Van den Bosch, & Volberda (2007)	Theory building	N/A	Proposed conceptual framework that inter-organizational relationships develop along vicious or virtuous cycles.
Kumar & Seth (1998)	Empirical survey	Survey of 128 joint party relationships in the manufacturing industry with at least one parent in United States.	Tested hypotheses and confirmed the importance of the degree of strategic interdependence and the moderating role of environmental uncertainty in explaining the design of control mechanisms.

Table 1, cont'd

Author	Method	Sample	Results
Garcia-Canal, Valdes-Llaneza, & Arino (2003)	Empirical survey	Eighty joint venture firms in Spain across all industry groups.	Tested hypothesis and concluded that the use of formal controls or relational investment depends on the number of partners in the joint venture.
Nooteboom, Berger, & Noorderhaven (1997)	Empirical survey	Ten suppliers of electrical/electronic components	Relational risk contains two dimensions: size of loss and probability of loss.
Sengun & Wasti (2007)	Interpretive interviews and quantitative survey	Study of 360 pharmacies in Turkey	Did not confirm Das & Teng's (2001) conceptual framework of trust, control, and risk in a buyer-seller relationship. Results suggest that goodwill trust increases the tendency to take performance risks, but not the tendency to take relational risks.
Doz (1996)	Longitudinal Case study	Case study of three strategic alliances of new business and new product development.	Successful alliances are highly evolutionary and pass through a sequence of interactive cycles of learning, re-evaluation, and readjustment.
Buono (1997)	Grounded theory case study	Consulting intervention in two network-type organizations	Presented an alliance-based intervention model to help managers and consultants conceptualize and improve critical issues related to creation, maintenance, and assessment in organizational partnerships.
Yan & Gray (1994)	Comparative case study	Four joint ventures between United States and People's Republic of China.	Confirmed previous research that the relative levels of joint venture partners' bargaining power had significant impact on the pattern of parent control in the management of the venture. Presented an integrative model of management control in joint ventures.

This body of research has yielded a wide range of knowledge and insights over the past two decades. From a methodological perspective, the majority of researchers followed a conceptual framework or empirical methodology approach and only a few researchers used a case study methodology. I explore and compare the use of these methodologies in the section below.

Conceptual framework

While Ring and Van de Ven (1994) and Das and Teng (1998, 2001) provided important conceptual frameworks to understand inter-organizational relationships and strategic alliances, additional researchers built their theories upon these frameworks and expanded the literature with their own models. In Inkpen & Currall's (2004) model, they linked trust, control, and learning together in a systematic fashion and proposed that these elements follow a co-evolutionary process. Within this process, they propose that "initial joint venture conditions give way to evolved conditions as joint venture partners develop an understanding of each other and adjust the collaborative process" (p. 586). However, the authors did not map the initial and evolved conditions of their model to specific stages of an alliance.

In other conceptual research, Adobor (2006) identified relationships as an important mechanism and control to shape and reach alliance objectives. According Adobor's (2006) lifecycle model, personal relationships are most important in the early phase of the alliance and should reduce in importance over time as the alliance matures. In addition, during the later stages of the alliance, Adobor (2006) proposed that personal relationships are more likely to create negative impacts on the alliance than in the early stages. Through my interpretive case study, I hoped to better understand how the development of trust within relationships evolves over the stages of the alliance lifecycle.

In a third conceptual framework, Vlaar, Van den Bosch, and Volberda (2007) proposed that managers will trust and distrust during initial stages of the inter-organizational relationship. According to their model, the degrees to which these managers experience trust or distrust will leave strong impressions on the development of these relationships in later stages of the collaboration and can create a high propensity for the inter-organizational relationship to develop along a "vicious or virtuous" cycle (p. 407). However, their model did not consider the inter-organizational relationships to be an informal control.

Thus, while several researchers have presented conceptual frameworks and these models are helpful to understand how controls and trust evolve in alliances, none have used field-based interpretive research to study the evolution of a successful alliance.

Empirical methodology

Other researchers conducted empirical research and built upon the theoretical frameworks of Ring and Ven de Ven (1994) and Das and Teng (1998, 2001) and tested their hypotheses on different elements such as the degree of strategic interdependence, environmental uncertainty, number of alliance partners and relational risk. In addition, these researchers tested the frameworks on different industries and geography around the world.

According to an empirical study by Kumar and Seth (1998) on 128 joint venture relationships in the manufacturing industry, the degree of strategic interdependence and moderating role of environmental uncertainty influences the design of control mechanisms. While this study identifies several types of formal controls, such as staffing and compensation, the researchers do not consider types of informal controls in their study.

In a study of 80 joint venture firms in Spain, Garcia-Canal, Valdes-Llaneza, and Arino (2003) tested two methods of joint venture management. Based on their research, Garcia-Canal,

et al. (2003) found that the adoption of either relational investment or formal control method of management depends on the number of partners in the joint venture. As such, the relational investment method was more effective for two-party joint ventures and the formal control method was more effective in joint ventures with more than two parties.

Some researchers found support and refuted findings for Das and Teng's conceptual framework. Das and Teng (1998) defined relational risk as the risk that firms will not be able to cooperate or that a firm will act in an opportunistic manner and take advantage of the other firm (Das & Teng, 1998). Survey research by Nooteboom, Berger, & Noorderhaven, (1997) confirmed that relational risk consists of two dimensions: size of loss and probability of loss and that they each have substantially different causes.

In contrast, Sengun and Wasti (2007) used an interpretive and quantitative study to analyze Das and Teng's (2001) trust, control, and risk framework in a buyer-seller relationship in the Turkish drug distribution sector. Based on their findings, Sengun and Wasti (2007) refuted Das and Teng's (2001) original model and suggest that goodwill trust increases the tendency to take performance risk, but not the tendency to take relational risk.

Case study methodology

In addition to empirical research on controls and relational risk, some researchers used case study methodology to test theories and discover insights. According to a longitudinal case study by Doz (1996), successful alliances evolve at a high rate and pass through a sequence of interactive cycles that include learning, revaluation, and readjustment while alliances that fail tend to experience high inertial, "little learning, or divergent learning between cognitive understanding and behavioral adjustment, or frustrated expectations" (p. 55).

Buono (1997) used a grounded theory case study methodology to propose an alliance-based intervention model to help manager and consultants visualize and address critical issues related to the creation, maintenance, and assessment in organizational partnerships. Finally, Yan and Gray (1994) used a comparative case study to understand the different levels of bargaining power across a joint venture's partners.

In summary, the conceptual frameworks yielded new knowledge and other researchers extended our understanding through their empirical survey research. However, while the empirical studies described above examine the parts of the phenomenon of successful joint ventures, the interpretive approach is under represented in the literature and needed to reveal how all the parts work together to form a whole (Merriam, 1998). Thus, I will describe my plan to study the phenomenon of controls and trust over the lifecycle of a joint venture as a whole using a interpretive case study methodology.

While many researchers have proposed theoretical models and frameworks about the lifecycle of alliances and the impact of trust on alliances, many questions remain unanswered. For example, the research suggests that changes occur in formal controls with changes in trust, but research has not yet been conducted to understand how formal and informal controls change. In addition, there is not yet an understanding of how trust, controls, and interpersonal relationships change over the full lifecycle (negotiation, commitment, and execution) of the alliance.

This research study explored these unanswered questions and seeks to gain insights and understanding into the factors that lead to successful alliances. I agreed with Ring and Van de Ven (1994) that firms go through a social and psychological process and ask themselves key social psychological questions as they move through each stage of the alliance lifecycle.

However, I believe that increased understanding of these processes and questions over the lifecycle of the alliance can help leaders to further increase the success rate of alliances. I will accomplish these research goals by asking the following questions:

RQ1: What roles do formal controls play in influencing the establishment of trust during each stage of the lifecycle?

RQ2: What roles do informal controls play in influencing the evolution of trust during each stage of the lifecycle?

RQ3: How do leaders experience trust during each stage of the joint venture lifecycle?

RQ4: What is the process to build trust within the joint venture?

Chapter Three

RESEARCH DESIGN AND METHODOLOGY

In the last chapter, I reviewed the research and theory that has advanced our knowledge and understanding in the areas of strategic alliances. In addition, through this review, I highlighted a gap in the empirically derived, in-depth understanding of the process of the joint venture, through the perspective of the leaders, and reflecting on their experiences of trust and the use of formal and informal controls. In the following chapter, I outline the design and methodology I will use to provide a deeper and richer understanding and description of how leaders experience trust over the stages of the alliance, how the use of formal controls and informal controls change over these stages, and the process to built trust within the strategic alliance.

Research Design and Rationale

The purpose of this study is to better understand the meaning that leaders construct about their experience with joint ventures and how this constructed meaning helped them understand their experiences and make sense of their world. According to Crotty (2003), the interpretative approach examines interpretations of the social world that are "culturally derived and historically situated" (p. 67). Thus, the interpretative epistemological perspective best aligns with my research goals.

Case Study Methodology

In this study, I ask "how" and "why" questions about this phenomenon, discover in-depth understanding, and gain insights into the phenomenon. As a result, I used an exploratory case study methodology for several reasons. First, case study is useful when asking "how" and "why" questions. Second, in this study, I had no control over the events, and third, I sought to study a

contemporary phenomenon within a real life context (Yin, 2009). Also, the case study methodology met my needs because I wanted to explain a phenomenon and identify operational links that were traced over time, rather than measuring the frequency of the occurrence (Yin, 2009). Finally, I examined contemporary events where relevant behaviors could not be manipulated and when systematic interviewing was possible (Yin, 2009).

My goal was to gain insight into the phenomena of control, trust, and interpersonal relationships. This goal was reflected in the content of my literature review which did not primarily provide answers about what is known, but provided a framework to develop sharper and more insightful questions on this phenomenon (Yin, 2009).

Based on my review of the relevant literature, many researchers used quantitative research methods or proposed theoretical frameworks (Ring & Van de Ven, 1994; Vlaar, et al, Das & Teng, 1998; Das & Teng, 2001) on alliances and joint ventures. However, very few researchers have used the interpretive case study methodology (Doz, 1996, Yan & Gray, 1994). I believe that this method is an underused research method and can be applied to uncover new insights and knowledge not available through other research methods.

Research Design

I sought to understand the complex phenomena as experienced by leaders in organizations who had first-hand experience working with alliances in all stages of the joint venture lifecycle. This required me to conduct an in-depth study, look for patterns among the phenomena in their natural context, and view the joint venture as the participants view it, while also maintaining my own perspective as an investigator of the phenomena (Gall, Gall, & Borg, 2005).

Thus, to accomplish these goals, I used an interpretive research design that provided me with flexibility to adjust the design as the study evolved. As I learned about the setting, people, and other sources of information, I further discovered what needed to be done to fully describe and understand the phenomenon (McMillian, 2004). Also, I began my study using interviews and document review on a case study of a successful joint venture and explored the role that a change in formal controls and informal controls and the evolution of trust played in its success**.** However, while I began my study with some idea about the data that I needed to collect and procedures that I would employ, a full account of the methods was described retroactively, after I collected all my data (McMillian, 2004).

Site and Participant Criteria

Site. The intended site for the case study will be two or more groups who formed an alliance to increase their competitive positioning and leverage unique strengths that each brings to the marketplace. To be able to study this phenomenon in its natural context, I will interact with leaders using their own language, on their own terms, and in their natural settings (Gall et al., 2005). In addition, I will study a joint venture because joint ventures are often selected as a strategy to make organizations more competitive and profitable (Inkpen & Currall, 2004).

Participant. Case study uses a bounded system to study the phenomenon and the goals of my study were to discover, understand, and gain insights into successful joint ventures. Therefore, I applied the following criteria to select participants to participate in my study:

- Leaders in the joint venture who participated in the negotiation, commitment and completed, or nearly completed, the implementation stages of the joint venture.
- Leaders who did not prematurely terminate the joint venture.
- The organization that participated in the joint venture within the past seven years.

After I identified individuals who met these criteria, I selected a small number of "key informants" with special knowledge or perspective in how and why the joint venture was formed, negotiated, and implemented (Gall et al, 2005). In addition, this method will allow me to conduct in-depth interviews with a small number of individuals instead of only reaching a superficial level of study with a large number of individuals (McMillian, 2004).

The number of participants for the case study was determined by the amount of information needed and received. One of the purposes of the interviews was to maximize information. Thus, I stopped my interviewing participants when the information I received from the interviews became redundant and no new information came forward (Merriam, 1998). By interviewing leaders with this knowledge and experience, I gained in-depth insights into how leaders experience trust, the process used to build trust, and the roles of controls that influenced the evolution of trust.

Site Profile

The actual site for the case study was Restorative Health, a joint venture formed by three health care organizations: Atlas Group, Great Plains University, and Central Health Care. These three organizations, located in the Midwest United States, joined together to increase their competitive positioning and leverage unique strengths that each brought to the marketplace. I gave the joint venture and the three partner organizations pseudonyms to ensure confidentiality and protect their identity. Table 2 provides a description of the three organizations that joined together to form the Restorative Health joint venture.

Table 2
Three Medical Groups that Formed the Restorative Health Joint Venture

Participating Firm	**Description**
Atlas Group	A small group of physicians in the Midwest who left a single-specialty physician group and pooled their money to invest in and form a single-specialty medical joint venture. They considered the joint venture as both an investment vehicle and an opportunity to continue their medical practice.
Great Plains University	Administrators and physicians within a department of a major medical university in the Midwest. The university department joined the joint venture to give their medical residents and fellows the opportunity to gain better work experience by seeing patients with more common and frequent needs which they would work with after graduation than the unique and unusual cases only seen within the university setting.
Central Health Care	A large multi-specialty comprehensive health care system in the Midwest which joined the joint venture in order to grow market share and infuse innovation and effective medical practices into their organization.
Restorative Health	Joint venture formed in the Midwest from three physician/health care-based organizations (Atlas Group, Central Health Care, and Midwest University).

Pseudonyms were used to protect the identity of organizations participating in the research study.

Participant Access, Selection, and Profile

I negotiated access to the leaders in the organizations and conducted interviews from January 2010 to July 2010. Prior to that time, I met with potential participants to determine if they meet the criteria for my study and to determine if they were willing to participate. Before conducting the interviews, I sent a copy of the consent form and information about the study to all leaders participating in the study for their review and approval (Appendix 2). Through this form, leaders received information about the purpose of the study, procedures to be used in collecting data, risks associated with participation in the study, their rights to voluntarily

withdraw from the study at any time, and the benefits they can expect to receive through their participation (Creswell, 1998).

The primary participants for the case study at Restorative Health were executive and department administrators and physicians of the three organizations who had first-hand experience in one or more of the stages of the joint venture lifecycle. Table 3 summarizes the profiles of the participants interviewed for the case study with their roles, joint venture partner affiliation, and stages of joint venture participation.

Table 3
Profile of Participants Interviewed

Name	Role			Joint Venture Partner Affiliation				Participation in Joint Venture Stage							
	Physician	Executive Administrator	Department Administrator	Atlas Group	Central Health Care	Great Plains University	Restorative Health	Form Business Concept	Negotiation 1	Design	Implementation	Restructure 1	Restructure 1.1	Restructure 1.2	Restructure 2 /Negotiation 2
Dr. Nelson	☐			○				■	■	■	■	■	■	■	■
Dr. Scott	☐	☐		○			○	■	■	■	■	■	■	■	
Dr. Olson	☐	☐		○			○	■	■	■	■	■	■	■	■
Dr. Hansen	☐		☐		○		○		■	■	■	■	■	■	■
Dr. Brown	☐		☐		○					■	■	■	■	■	■
Dr. Jones	☐		☐		○					■	■	■	■	■	■
Mr. Miles		☐			○				■	■	■	■	■	■	
Dr. White	☐	☐	☐		○	○	○	■	■	■	■	■	■	■	■
Dr. Stevens	☐					○				■	■	■	■	■	■
Ms. Wilson		☐				○			■	■	■	■			■
Ms. Matthews		☐					○				■	■	■	■	■

Pseudonyms were used to ensure confidentiality of responses and protect the identity of subjects.

Data Collection

I used interviews, member checking, and document analysis as multiple methods to gather and analyze data and to gain a greater depth of understanding from my research results. These methods are described below.

Interviews

Interviews were an important source of data because I was not able to observe behavior, feelings, or how the leaders interpreted their world. Also, interview data was necessary because the events to be studied had already passed and they were impossible to replicate (Merriam, 1998).

To help me gain insights and understanding from leaders, I used an open-ended and semi-structured interview format (Appendix 3). This format provided several advantages. First, by using a less structured format, the interview was guided by a list of questions to be explored. However, neither the exact wording nor the order of the question was determined in advance. This allowed me to respond to the situation at hand, allow the leader to define their joint venture experience in unique ways, and to respond to new ideas on the topic (Merriam, 1998). Secondly, open-ended interview questions allowed participants the freedom to answer questions on their own terms rather than selecting a fixed set of answers (Gall et al, 2005). The use of interview questions was informal and occurred through the natural course of conversation (Gall et al, 2005).

Using "why" and "how" questions, I asked leaders to describe their experience during different stages of the joint venture and asked them to describe examples of trust or lack of trust they experienced during each stage. Also, I asked leaders to describe how they experienced formal and informal controls during the lifecycle and how these controls increased or decreased

over the lifecycle. I needed participants who were not hesitant to speak and share their ideas, and I used private conference rooms and offices as a setting where the participant could feel comfortable to speak and talk openly (Cresswell, 1998). All my interviews were conducted face-to-face at the participants' workplace.

Prior to holding the actual interviews with leaders, I held a pilot interview to try out my questions, gain practice asking probing questions, and determine which questions were confusing and needed to be reworded (Merriam, 1998). I made an audio recording of the interviews and hired an outside party to transcribe the interviews. As I analyzed and coded the transcripts I recorded field notes. To protect the anonymity of the individuals in the study, I assigned numbers and aliases to the participants (Cresswell, 1998).

Construct Validity

Construct validity was established for the concepts in this study. To increase construct validity, I did three things: First, I gathered data from multiple sources in a way that the lines of inquiry would converge during the data collection. Second, I worked with the data to create a "chain of evidence" during the data collection stage. Finally, I used member checking and asked key informants in the study to review draft copies of the report (Yin, 2009).

Document and Data Analysis

In interpretive research, the data analysis stage represents a search for meaning and a search for patterns (Stake, 1995). As such, I interviewed participants, observed workflow and took a guided tour of the joint venture facility, attended a Board meeting, and reviewed written communication. The written communication included legal contracts, formal policy statements, and written communication about the structure and interaction between people in the joint venture. As I did these activities, I watched and listened for clues to instances of formal and

informal controls and trust. I noted these clues and observations and added them to my interview notes and document analysis as I organized, transcribed, coded, summarized, and interpreted the data (McMillian, 2004).

After transcribing the interviews, I imported the transcripts into ATLAS ti 6, an interpretive research software, to help me process, analyze, and organize the data. As I coded the transcripts, I saw several themes and significant events that happened over the lifecycle. To better organize the data, narrate, and analyze the story of this case, I segmented the lifecycle into eight stages and grouped many of the codes within one of the eight stages.

The first four stages were similar to the first stages described by Kanter (1994) of form business concept, negotiation, design and implementation. However, after the financial crisis, the changes made to the organizational structure represented important stages in the lifecycle that could not have been predicted. Thus, I added these stages to the lifecycle and my analysis. By organizing the events and changes as they occurred within one of the stages, I was better able to analyze and describe the joint venture as a narrative.

Based on my data analysis and creation of codes, I grouped the codes into 80 different code families to help me identify key themes. For example, there were 108 statements coded from the interviews that referenced a change in formal controls during the phase I labeled as Restructure 1. In contrast, there were between 5 to 24 references of changes in formal controls during the other stages of the lifecycle. Through this analysis, I could identify the high and low spots in the frequency of changes in formal and informal controls and trust across the lifecycle.

After analyzing the code families and quotes within the code families from Atlas ti 6, I re-read key quotes and codes, manually plotted them along a timeline grid, and color-coded the quotes based on changes in controls and trust. This grid allowed me to further analyze formal

and informal controls that emerged and changes in trust during the eight stages of the lifecycle in single-visual view.

Due to the high volume and complexity of quotes and codes within each stage in the timeline grid, I created separate tables and summarized the themes and changes in trust for each of the three formal and informal controls. By moving the themes and codes into separate tables, I was better able to analyze, condense, synthesize, and report the results via the tables in throughout this chapter.

Member checking. I used member checking at two points during my data analysis process. First, early in my data analysis process, I shared a draft copy of the lifecycle results section with three key informants to get feedback and validation on the initial lifecycle and themes that emerged from my analysis. The informants validated the lifecycle and clarified details on the actors, their role in the stages of the joint venture, and the sequence of some events over the lifecycle. I conducted my second round of member checking towards the end of my analysis. During this round, I shared an executive summary draft of the results with five key informants who represented all parties involved in the study (Yin, 2009).

During both rounds of member checking, I met with my informants via phone and face-to-face, and asked them to provide me with critical observations and interpretation and to review my draft materials for "accuracy and palatability" (Stake, p. 115, 1995). During the second round of member checking, the informants validated my executive summary and interpretation, reiterated their strong beliefs and memories of the themes that I had documented, and further described how these themes had played out over the eight to twelve months since my initial interview with them. Using the validated results and the additional data they shared with me

during the member checking meetings, I further refined my analysis and report in the results chapters.

In summary, my methodology for data analysis was based on the structure and approach proposed by Stake (2010), and was a "search for both elements and associations" and an "ongoing, iterative and habituated inquiry processes" (p.137). While much of this stage of the research was an "intuitive process" because there are "few recipes for analysis and synthesis", the structure, the suggestions by Stake (2010) were helpful.

Summary of Methods Chapter and Introduction to Results Chapters

The purpose of this research study is to answer the following research questions:

RQ1: What roles do formal controls play in influencing the establishment of trust during each stage of the lifecycle?

RQ2: What roles do informal controls play in influencing the evolution of trust during each stage of the lifecycle?

RQ3: How do leaders experience trust during each stage of the joint venture lifecycle?

RQ4: What is the process to build trust within the joint venture?

Answers to these questions came through interpretive interviews with executive administrators, department administrators, and physicians, and the data was rich and extensive in detail.

To analyze the data, I followed the process I described in Chapter 3. I transcribed the interviews and paraphrased quotes into codes. Next, I assigned the codes into code families and sub-families. The process of analyzing and assigning codes into code families and sub families created over 80 sub family codes. The majority of the codes and sub family codes fit into one of eight job families which represented the eight stages of the lifecycle. After following this process to analyze and sift through the data, I organized the results into four separate chapters.

In Chapter 4, I describe of the lifecycle that Restorative Health followed. In Chapters 5 and 6, I describe the impact of formal and informal controls on trust, and describe how leaders experienced trust in Chapter. 7. Following these chapters, I discuss the meaning and implications of the results in Chapter 8.

Chapter Four

RESULTS – JOINT VENTURE LIFECYCLE OF RESTORATIVE HEALTH

Restorative Health executive administrator: . . . it's been a rollercoaster ride.

Central Health Care administrator/physician: All the fun, all the turbulence.

The concept to form a joint venture between practicing physicians and a medical university started many years before the joint venture was formally organized and launched. The concept was initially created by a group of physicians who worked together in a single-specialty center who saw an opportunity and need to expand programs and increase levels of service. The physicians envisioned an organization where physicians would practice clinical and surgical medicine in a facility where the equipment and facilities were world-class and the design of the facilities provided patients with an outstanding level of service. In addition, the physicians envisioned a practice where physicians with clinical and surgical expertise could practice medicine, conduct research, and work alongside and mentor medical trainees in residency and fellowship programs.

However, the physicians' employer was not open and did not support the ideas of expanding programs or raising levels of service. As a result, the physicians felt so strongly about their vision that they left their employer and went to practice medicine on their own while they continued to pursue their goal to create their envisioned organization.

Restorative Health Joint Venture Lifecycle

To discover insights into what formal and informal controls were used, how these controls changed, and how trust evolved, I asked administrators and physicians several open-ended questions from my list of semi-structured interview questions listed in Appendix 3. At the beginning of the interview, I asked participants to tell me when they got involved in the joint

venture and to describe their experience over the lifecycle. By asking these questions, the participants easily opened up and told me the story from their perspective of how Restorative Health came into existence, their role, and the ups and downs of the joint venture. Through these initial questions, participants shared with me a lengthy and detailed narrative that included significant events, changes, and impacts from these events and changes.

As I analyzed the events and changes they shared through individual interviews, I created a composite timeline of the joint venture and organized the narrative into eight stages described in Table 5. The first four stages (Form business concept, Negotiation, Design, and Implementation) aligned with stages of most strategic alliances as described by Kanter (1994). However, I saw a shift away from Kanter's (1994) model in stages as Restorative Health experienced a financial crisis and leaders made one major and two minor changes to their organization structure before negotiating and restructuring the joint venture at the end of the lifecycle. In the following section, I describe each stage in further detail.

Table 4
Eight Stages in the Restorative Health Joint Venture Lifecycle

1. Form business concept

   A physician and administrator from Great Plains University met with Atlas Group, group of physicians and private investors, to explore the opportunity to create a single-specialty health care joint venture. The driving vision for the joint venture was to improve the health care experience for the patient, physician, and medical trainee.

2. Negotiation 1

   Central Health Care, a large multi-specialty comprehensive health care system, became the third party and majority owner in the joint venture. Physicians at Great Plains University shared the vision and goals of the joint venture and their reaction to participation was mostly positive. Executive administrators of each party in the joint venture believed that information and dialogue about the joint venture was taking place with the Central Health Care department. However, unbeknownst to the executive administrators, this communication did not fully take place with all levels in the Central Health Care department and a lack of consensus among Central Health Care department did not get communicated back to the executive administrators. Thus, leaders completed their negotiations and agreed to move forward with the joint venture.

3. Design

   Representatives from all three parties spent considerable time together to discuss and shape the joint venture so that expectations were understood and outcomes would be beneficial to all parties.

4. Implementation

   Within a few months after Restorative Health opened for business, several events happened that were unexpected and different from what was agreed upon in the negotiations. As a result, Restorative Health fell short of their financial goals and could not cover their operating expenses. This caused leaders from Central Health Care, as majority owner, to consult with leaders of the other two partners on options to take.

5. Restructure 1

   Leaders of the three parties agreed to restructure the joint venture with Central Health Care as sole owner of one of the divisions of the joint venture and agreed to adopt their systems and processes. Changes made during this stage strained relationships and damaged trust between parties and individuals.

Table 4, cont'd

6. Restructure 1.1

   To overcome conflicts and rebuild trust, Central Health Care created a new service line. As a result, physicians who worked at Restorative Health and Central Health Care physicians who did not work at Restorative Health now reported into the same service line and administrator.

7. Restructure 1.2

   After several years of persistence and hard work, Restorative Health became financially stable and profitable. The service line shared by Restorative Health and Central Health Care physicians who did not work at Restorative Health was disbanded and Central Health Care physicians who did not join Restorative Health reported to a separate administrator.

8. Negotiation 2/Restructure 2

   Leaders from the three parties negotiated and agreed to reorganize and combine all divisions of the joint venture within one legal structure and continue the joint venture with some changes to their reward system and reporting structure.

Form business concept. When Dr. White, a health care administrator and physician, interviewed for a leadership position at Great Plains University, a major medical university in the Midwest United States, he was introduced to Dr. Scott. Dr. Scott was a member of the Atlas Group, a group of physicians who practiced medicine and wanted to become private investors and continue their practice as physicians by forming a single-specialty health care joint venture. Dr. White, Dr. Scott, and the Atlas Group quickly formed a bond because they shared common goals and vision "from the get go" on how the health care experience could be improved for the patient. In addition, they were unified in a vision to improve the health care experience for the physician and to improve the education experience for the medical student during their residency and fellowship program.

After accepting the department administrator position at the university, Dr. White arranged for the physicians in his department at Great Plains University to join the joint venture to provide patients and teaching and research experiences for residents and fellows within the university medical program. As Dr. White and Atlas Group developed their business model,

they realized that they needed "a *bank* that believed in the vision" which they expected to be found in the form of a large health care system that agreed to join the joint venture as a third partner. A health care system could assist the joint venture by providing a large and steady revenue stream of patients to grow the business. By joining with such a partner, the groups hoped to not only build and expand the services and programs they envisioned, but also to share the revenue streams across the partners.

Negotiation 1. After several years of searching and many meetings where leaders presented their business concept and vision to different health care organizations, a third partner was identified. Central Health Care, a large health care system in the Midwest that, was very interested in participating in the joint venture with Great Plains University and the Atlas Group. Executive administrators of Central Health Care agreed and supported the goals, vision, and entrepreneurial model presented to them. Executive administrators of the Central Health Care shared information about the potential joint venture with their department administrators and physicians and requested and considered input from their physicians. According to the high-level proposed design of the joint venture, the practicing physicians from all three partners would move their practice and their patients to the joint venture facility.

According to a Central Health Care administrator/physician, reaction to participation in the proposed joint venture by Central Health Care department administrators and physicians at Central Health Care was mixed since "this obviously had the potential to impact everybody at Central Health Care." There were a "variety of responses." Some felt it was a "good idea," a "good opportunity," and "I'm sure we could make this work" while others expressed "no, we don't want to do this, it sounds like a recipe for disaster for us." Concerns expressed by some Central Health Care physicians were not reported back to executive administrators at Central

Health Care and Restorative Health, and Central Health Care executive administrators agreed to move forward and join the joint venture.

Design. As the negotiation stage ended and the design stage started, all three parties bought into the joint venture concept and contributed to the design of the joint venture. During both the negotiation and design stages, all three groups spent considerable time together to discuss and shape the concept and make sure it made sense from all perspectives. As leaders designed the joint venture, they sought to attract additional physicians with specialties to join the joint venture. Prior to formal sign-off of the contract and pro forma, leaders of the three parties agreed to several things, including:

- Each member of the Atlas Group invested a portion of their own money ($5M in total) to become private owners and gain equity ownership in the clinic.
- As non-profit organizations, Great Plains University and Central Health Care would contribute a portion of money ($3.5M in total) to the venture to become institutional investors.
- Each partner would bring over a specified amount of business to the joint venture.

In many ways, the negotiation and design to form the joint venture took place simultaneously in two phases. After formal sign-off, the negotiation and design of the joint venture continued as operational details and plans for the joint venture were discussed and agreed upon. During the design phase, the three-party joint venture was named Restorative Health and Ms. Matthews was hired as President and COO. Ms. Matthews' first priority was to hire her management team and lead and manage Restorative Health on behalf of the three parties to achieve the founders' vision and mission.

Implementation. Within a few months after Restorative Health opened for business, several events happened that were unexpected and different from what was agreed upon in the contract. The following events changed the structure and course of the joint venture:

- Financial projections written into the pro forma/business plan proved to be unrealistic.
- The pace and rate of Great Plains University and Central Health Care physicians moving over their practice and patients to the Restorative Health facility was lower and slower than projected and agreed upon.
- Three physicians with high volume practices left Restorative Health and moved out of the area for personal reasons.
- Additional physicians from outside the joint venture did not join the joint venture as originally envisioned.
- Competing health care systems offered their physicians financial incentives to not participate in the joint venture.
- Administrators at Central Health Care did not adequately communicate the need for their physicians to support the joint venture and, encouraged, but would not force, their physicians to move their full practice to the Restorative Health facility.

As a result, Restorative Health fell short of their financial goals within their first six months and was unable to cover their payroll. These events forced the leaders to face a difficult and painful decision to either close the doors and disband the joint venture or find someone willing to cover the debt they had incurred. Leaders from Central Health Care, who held majority ownership, consulted with the other two partners on the different options. While

leaders weighed their options and considered the best solution, Central Health Care covered the payroll and debt payments for all parties in the joint venture.

Restructure 1. After a short and rushed deliberation, leaders of the three parties agreed to restructure in order to keep Restorative Health open. Under this agreement, several organizational changes were made: Central Health Care became sole owner of one of the divisions of the joint venture and Restorative Health's technology and HR systems were changed and brought under the systems and processes used by Central Health Care.

These unexpected events created many changes for all parties and the years following the restructuring were difficult for administrators, physicians, and staff working at Restorative Health. While Atlas Group and Central Health Care physicians generally worked well with Great Plains University, the trust and relationships between the Atlas Group and Central Health Care was strained and distrustful. A key factor in the conflict was from Central Health Care physicians who chose not to join Restorative Health and openly objected to Central Health Care's involvement in Restorative Health. Also, while some Great Plains University physicians agreed in principle to join Restorative Health, some Great Plains University physicians chose not to join during the Implementation stage. During the restructuring, trust among the parties was "at an all time low for about a year."

Restructure 1.1. In an attempt to overcome these conflicts and bridge the gap between the parties, Central Health Care executive administrators created the Patient Care Service Line as a new service line within Central Health Care. Under this new line of service, staff and the physicians who worked at Restorative Health and Central Health Care physicians who did and did not work at Restorative Health now reported to the same service line department administrator at Central Health Care. This structural change required the creation of a new

position. Dr. White, department administrator at Great Plains University, was selected over two Central Health Care department administrators who interviewed.

As Dr. White left his department administrative position at Great Plains University and moved into his new department administrator role at Central Health Care, he worked hard with Ms. Matthews to lead both the Patient Service and Restorative Health service lines. However, cooperation and relationships between the three parties and the Central Health Care physicians that did not join Restorative Health continued to be difficult. One reason for the difficulty was that when Central Health Care rescued Restorative Health, some people at the Central Health Care believed that Restorative Health would be assimilated into the Central Health Care culture, since Central Health Care had become the dominant owner and party in power in the joint venture. However, that belief was opposite from the goals and plan of Ms. Matthews and Dr. White who were given the charge from the Central Health Care executive administration to maintain Restorative Health as a separate entity and culture. This direction surprised and frustrated some people at the Central Health Care because they perceived that Restorative Health unfairly received too much attention and too many resources from Central Health Care to stay in operation. Also, some people at Central Health Care viewed Restorative Health as a drag on resources and budget that should instead go towards their departments and the larger Central Health Care organization.

Restructure 1.2. Several years after Restructure 1, Restorative Health eventually became financially stable and profitable. However, relationships were still strained between Central Health Care physicians who chose not to join Restorative Health and physicians working at Restorative Health. As a result, executive administrators at Restorative Health and Central Health Care made the decision to disband the Patient Care line of service and restructure the

reporting relationships so that physicians at Central Health Care who did not join Restorative Health reported to a different department administrator.

As a result of the persistence and hard work of many people, Restorative Health eventually experienced positive cash flow, profitability, and many signs of success. The Restorative Health surgery center experienced significant rates of growth, medical trainees and fellows repeatedly gave the joint venture high marks for high satisfaction in their residency training, and several programs in the clinic were expanded.

Physicians and administrators from all three parties who were involved with Restorative Health from the beginning felt a great sense of satisfaction, accomplishment, and pride. This pride came not only from the success that Restorative Health achieved, but also from the challenges and obstacles they overcame together. However, at this point in the Restorative Health life span, several leaders described Restorative Health's success as "qualified" and "partial" because they acknowledged that Restorative Health had not yet reached the full vision of what it could become. To some in the Atlas Group, full success would only come after receiving financial rewards from their investments in the joint venture.

Negotiation 2/Restructure 2:

> Central Health Care administrator/physician: . . . we have weathered this incredible storm, I look at it, I say this is like a ship and you've sailed through a hurricane and your mast is broken and your sails are torn and it's just been a horrible experience and the hurricane's gone, the sun is shining, the wind is blowing again, you're repairing the ship and let's get going, we're 500 miles off course, we have to completely change our direction . . . So, now the point is the storm's over, let's get on with it, the ship's repaired, let's get sailing, . . . let's head for that destination again . .

When leaders and administrators from the three parties agreed to the terms of Restructure 1, they agreed that the change in structure would be a temporary arrangement. Under the Restructure 1 agreement, the parties would return Restorative Health to its original structure at

the time of implementation after the joint venture reached profitability. Two key elements of this return to the original structure was that majority ownership status would move from Central Health Care back to more equal three-way ownership across the three parties and Atlas Group could again receive some equity ownership.

However, perceived and actual differences in Atlas Group compensation and the lack of opportunity for Great Plains University and Central Health Care physicians to receive equity ownership had become deep and long-standing issues of conflict and frustration over the years. Health care laws and regulations prevented physicians of non-profit health care organizations from receiving equity ownership. These issues caused the three parties to question their continued participation in the joint venture.

In addition, a different group of independent physicians had formed their own joint venture with a competing health care system within a few miles of Restorative Health. Thus, the parties had three options: continue operating under the same business model with the same underlying conflicts and frustration, walk away from the joint venture, or compromise and reach consensus on a new business model. After several months of discussion during the Negotiation 2/Restructure 2 stage, leaders of the three parties agreed to continue with the joint venture and made changes to their compensation and organizational structure.

Conclusion

This chapter described the eight stages of the Restorative Health joint venture. During the early stages, leaders from three parties formed the business concept and worked together to negotiate and design the joint venture. After the implementation stage, the joint venture faced several unexpected events that created a financial crisis for the three parties. In order to keep the joint venture alive and operating, leaders agreed to restructure the joint venture.

Over the next few years, the three parties struggled to work together and trust each other. As a result, leaders made two additional organizational changes to better align the structure and better shape people's attitudes and behaviors to reach the goals of the joint venture. After these changes and several years of hard work, the joint venture became stable and financially successful. At this point, leaders agreed to continue their partnership, renegotiated their contract, and restructured their financial reward system and reporting structure for better future success and teamwork across the joint venture.

Chapter Five

RESULTS – FORMAL CONTROLS

As stated earlier in Chapter 2, joint ventures frequently establish controls to create predictability, stability, and to manage and mitigate relational risk. Controls help firms regulate the behavior of alliance members and govern and structure the relationship to meet objectives of the alliance and its partners (Costa & Bijlsma-Frankema, 2007). Controls can be formal or informal and provide structure, define behaviors, and minimize risk. Chapter 5 will describe formal controls and Chapter 6 will describe informal controls used by executive administrators and physicians and how the use of these controls changed over the life span of the joint venture.

To gather data on Research Question 1 and discover insights into the role of formal controls and how these controls changed over the lifecycle, I asked participants questions and listened for clues to answer two main questions:

How were formal controls (i.e., legal contracts, policies, and procedures) used during the negotiation, commitment, and implementation stages of the joint venture?

How did a reliance on formal controls change over the lifecycle of the joint venture?

In Table 5 below, I describe the code families and sub-code families according to the lifecycle stage of the joint venture where the control developed or changed as reported during my interviews.

Table 5
Formal Controls Code Family and Code Sub-family

Code Family	Code Sub-family	Quotes within Sub-Family
Design	Development/Change in Formal Controls – Differences between full-time/part-time physicians	7
	Development/Change in Formal Controls – Process, contract, design for operations and support staff, representation at meetings	35
	Development/Change in Formal Controls – Staffing	6
Negotiation	Development/Change in Formal Controls	5
Implementation	Development/Change in Formal Controls	16
Redesign 1	Change in Formal Controls – Facts about differences in compensation plans	4
	Change in Formal Controls – Feelings about compensation and equity	32
	Change in Formal Controls – Central Health Care takes assets	8
	Change in Formal Controls – Staffing	5
	Change in Formal Controls – Technology systems, standard procedures, ,organization structure	21
Restructure 1.1	Change in Formal Controls – Hire Dr. White as CEO	21
Restructure 1.2	Change in Formal Controls – Restorative Health and Central Health Care Department report to separate leaders.	11
Restructure 2	Change in Formal Controls – New financial incentive plan	7

Based on these family and sub-family codes, three main types of formal controls emerged from interpretive interviews over the life of the joint venture: financial reward systems,

organizational structure, and the selection and placement of leaders in the joint venture. As described below in Table 6, each type of formal control was adjusted and changed over the lifecycle of the joint venture with varying impacts on trust.

Table 6
Key Themes in Formal Controls and Impact on Trust

Formal Controls	Impact on Trust
Financial Reward Systems	Adjusted over the lifecycle with overall negative impact on trust.
Organizational Structure	Adjusted over the lifecycle with overall positive impact and some negative impact on trust.
Selection and Placement of People	Adjusted over the lifecycle with overall positive impact and some negative impact on trust.

Individual equity ownership, base compensation, and incentive plans were three financial incentives used by executive administrators as formal controls to shape and influence behavior and attitudes to achieve the goals of the joint venture. Overall, financial controls had a negative impact on trust because financial reward systems were designed and administered differently across the three parties. As reported by physicians from Central Health Care and Great Plains University, these differences created long-standing feelings of unfairness, inequity, and jealousy.

> Central Health Care physician: . . . we felt that the compensation system was grossly unfair . . . that's always been at the root of a lot of the ill feelings . . .

> Great Plains University physician: . . .in the days when we were all in negotiation, we gave a lot of our personal time and energy, which I think was fully recognized and . . . well it might have been recognized but it wasn't monetarily recognized. And it seems that every time anybody in Central Health Care does anything, it's compensated for.

As described in Table 7, physicians and administrators reported that all three of these financial reward systems negatively impacted trust over the life span of the joint venture.

Table 7
Financial Reward Systems and Impact on Trust

Financial Reward Systems	**Description of Formal Controls, Changes in Controls, and Impact on Trust**
Individual Equity Ownership	Atlas Group physicians initially received individual equity ownership, but Great Plains University and Central Health Care physicians did not receive equity ownership. This difference created feelings of inequity and negatively impacted trust over the lifecycle of the joint venture. After Restructure 1, equity ownership was removed, but a promise was given to restore equity ownership when joint venture was stable and profitable. During Negotiation 2/Restructure 2, a reward program was restored that mirrored equity ownership for all parties.
Base Compensation	Atlas Group physicians and Great Plains University physicians were paid a higher base compensation rate as contractors and Central Health Care physicians received lower base compensation along with benefits package from their employer. This actual and perceived difference created feelings of inequity and negatively impacted trust over the lifecycle of the joint venture. In Negotiation 2/Restructure 2, all parties agreed to be paid as contractors.
Incentive Plans	After Restructure 1, all parties were eligible to participate in an incentive plan. If performance goals were met, the incentive was paid to all three partner organizations and the organization decided how to distribute the money. For example, Central Health Care shared the incentive payments with all their physicians, including those who did and did not work at Restorative Health. This effort by Central Health Care executive administrators to create equity among their physicians failed to improve trust.

The following section provides greater details on the impact of these controls over the life span of the joint venture.

Individual Equity Ownership. During the Negotiation 1 and Design stages, all three parties invested money into the joint venture. As not-for-profit organizations, Great Plains University and Central Health Care became institutional investors. The Atlas Group consisted of a small group of physicians who formed a for-profit group so they could invest their money as individual investors. Individual equity ownership was an important factor to the Atlas Group

and this ownership motivated them to ensure that the joint venture was successful and that they would receive a return on their investment.

During Restructure 1, Atlas Group lost their individual equity ownership, but executive administrators promised to reinstate the equity ownership when Restorative Health became stable and profitable again. As Restorative Health grew and became financially strong, the Atlas Group sought to again reinstate the equity ownership so that they could recover their initial losses and again start to receive a return on their investment.

However, Central Health Care and Great Plains University physicians could not receive individual equity ownership and this caused negative feelings of inequity and frustration. To the disappointment of Central Health Care physicians, Central Health Care did not offer an individual incentive program to their physicians because Central Health Care was a multi-specialty comprehensive health care system and individual equity ownership would take away from fair treatment of all physicians within the Central Health Care system. This policy frustrated some Central Health Care physicians that worked at Restorative Health because while the Atlas Group could invest their money, receive equity ownership, and potentially receive financial rewards for financial success, any equity benefits that Central Health Care or Great Plains University received would not benefit individual physicians from Great Plains University and Central Health Care who worked at Restorative Health.

Base Compensation. According to the agreement made during the Negotiation 1 and Design stages, Great Plains University and Central Health Care physicians would be paid a base salary that included health care coverage and other insurance benefits normally covered by an employer. Atlas Group physicians negotiated to be paid through an independent contractor

agreement because they had different overhead costs and did not want to use the same compensation and benefit plan as Central Health Care and Great Plains University.

As a result, Atlas Group physicians were paid at a higher rate to cover their individual health care insurance, malpractice insurance, and other benefits. However, according to a Central Health Care administrator/physician, this perceived and actual difference in pay rates created distrust and frustration for some physicians who believed that the Atlas Group physicians were unfairly paid at a higher rate and that a physician from any of the three parties should be paid equally for performing the same work.

> Central Health Care administrator/ physician: The only thing…the only power that a situation like this has is money. You know, I mean we tried to create a beautiful; we did create a beautiful facility at Restorative Health. Well, that wasn't enough. Even though we ranked our (Central Health Care facility) here as one of the worst ones, people still had their allegiances geographically and physically to this plant and they stayed here. So, a beautiful facility, a beautiful (operating room), well that didn't really happen, a new (operating room) type of way of doing business or doing work in the (operating room) to make things flow more efficiently and all that. That didn't happen. Oh, the dictation system, the new…you had to learn a new dictation system, a new computer system, a new this and that, and some of these things didn't work all that well. So, ... what is the common motivator for anything? Money!

After Restructure 1, administrators at Great Plains University made a change to their compensation system and their physicians working at Restorative Health became independent contractors of Restorative Health and received the pay rate they negotiated. While Dr. White explained the difference in compensation rates between the Atlas Group and Central Health Care to Central Health Care physicians many times, they did not believe the data or explanation and chose to "have a different interpretation of things."

> Restorative Health executive administrator: . . . (Central Health Care physicians) understand (the Atlas Group compensation plan) and it's been explained to them a myriad number of times, countless times, they just don't believe it. They choose to have a different interpretation of things.

Despite the objections and frustration from some Central Health Care physicians to the higher and different base salary plan of the Atlas Group physicians, the different compensation plans remained in place through Restructure 1, 1.1, and 1.2 which negatively impacted the development of trust. During Negotiation 2/Restructure 2, all parties agreed to be paid the same base salary as contractors.

Incentive Plans. During Restructure 1, joint venture leaders developed an incentive program. They believed this incentive program would motivate Great Plains University and Central Health Care physicians to move their practices to Restorative Health and increase patient volume and improve financial performance at Restorative Health.

This incentive was meant to replace the individual equity ownership option with an alternative mechanism for physicians to participate in the profitability. The aim was to align incentives across all physician partners, build a unified culture, help partnering organizations benefit from Restorative Health as a whole, and maintain their commitment to build Restorative Health into a successful venture. The Atlas Group agreed to the program, but Great Plains University opted out of the incentive program during the first year of the contract due to perceived high risk. A year later, Great Plains University amended their contract and they participated in the incentive plan.

According to the incentive plan, physicians would receive a financial bonus when certain metrics were achieved. This incentive was to be equally divided across the three parties. However, under Central Health Care policies, when a financial incentive is paid from Restorative Health to Central Health Care physicians, Central Health Care chose to put the financial reward in a fund to benefit the entire department of Central Health Care physicians, including those who worked and did not work at Restorative Health.

To Central Health Care physicians who worked at Restorative Health, this incentive plan did not seem fair because there were fewer physicians at the Atlas Group than Central Health Care, so the incentive reward received by physicians the Atlas Group was higher than for physicians at Central Health Care. Physicians from all three parties recognized this problem.

> Central Health Care physician: . . . (what) I would like to see happen is restructured Restorative Health, hopefully, being fair and saying if you're a Central Health Care doctor we'll pay you $50 per (unit of measurement). If you're a Atlas Group doctor we'll pay you $50 per (unit of measurement), if you're a Great Plains University doctor we'll pay you $50 per (unit of measurement), if you're a private contracted person who just happens to come to Restorative Health, Joe Physician, we'll pay you $50 per (unit of measurement) or whatever and you know what, we'll give everybody the same level of support. If you're here full time in clinic you share this many staff people, you do this, you do that, so that everything is equal amongst the people that practice there.
>
> Atlas Group physician: And the most difficult thing in the whole bit is the physicians on the Central Health Care system because they are a multi-specialty group that basically is a--they don't have an individual incentive program within their system. One doc doesn't get treated any differently than another doc. And it's really hard.
>
> Great Plains University physician: . . . (Central Health Care physicians) very rarely referred (patients) to (Restorative Health). (Central Health Care physicians) very rarely referred (patients) outside of Central Health Care. (Central Health Care physicians) had disincentives in place not to refer outside (Central Health Care).

As a result of the perceived inequity, executive administrators adjusted these controls as part of the changes in Negotiation 2/Restructure 2 so that financial reward systems would have a more positive impact on behaviors and attitudes and the development of trust in the future.

Looking back over the first five years of Restorative Health, the leaders recognized how important and frequently contentious the issue of financial rewards had become for the parties in their joint venture.

> Atlas Group physician: All these partners from Central Health Care are working here because it’s a great place to work and they share the vision and they’re willing to partner up and share with us. They don’t derive any personal benefit from it and so in many respects I have an ultimate respect for the commitment of the Central Health Care physicians and the other Central Health Care docs who share here because it was identified early on as a potential problem was when you don’t have everybody…you

> have administration from Central Health Care going in the direction and being supportive of this place but not all the docs bought into this place and Dr. Scott identified before we ever did this place that unless we could find some way to incentivize the Central Health Care docs or to reward the Central Health Care docs, unless Central Health Care could somehow find a way to reward them, there were going to be problems. He identified that from the get-go.

While leaders designed, implemented, and restructured the financial reward systems, they found that these formal controls had an overall negative impact on behavior, attitudes, trust, and the achievement of joint venture goals.

> Central Health Care physician/administrator: Yeah, so if you compensated Central Health Care doctors that went to Restorative Health, preferably but the other Central Health Care docs didn't have the opportunity, that would cause a tremendous dissension within our ranks and so we did this as a shared pool. Now, what happened is per capital, if you will, for the people who are practicing there, it's pretty much the same. So now you take a…the guys that are in Atlas Group that are there 100% and can do that, their now individually getting an individual share, whereas in Central Health Care, everybody's getting 40% of a share. Well, what the heck is this, you know? So, . . . guess who's paying to keep the place alive? Central Health Care.

> Central Health Care physician/administrator: . . . I'm a witness to collateral damage in my department because some people are part of (Restorative Health) goals but other people are not. We could never all seem to get on board because the feeling was that things were unequal. And it starts with the simplest of all things . . . you've got to get paid the same amount of money and I don't think you can get past that. . .

> Great Plains University physician: Physicians are autonomous people who want things done their way; especially in our medical specialty. We're bullheaded. We're feisty. We work hard, we work incredibly hard, but we're used to having payback for that work.

As a result, leaders gained an insight that without giving physicians from all parties pay equity or a stake in the ownership of the joint venture, they would not be vested or likely to trust one another.

> Central Health Care administrator/physician: So, without an ownership stake, what do you do?

> Central Health Care physician: So the advantage (for physicians) of bringing patients (to Restorative Health) would be is it easier for the doc to work here. Do they like the operating room better? Is it easier for the patient to park? Are the people who deal with them more pleasant? You know all those sorts of intangibles, but (the Central Health

> Care physicians are) still taking something out of their system and plunking it (at Restorative Health). And so how do you get them to say you know what, this is really a great place, because it doesn't make any difference to them. They don't make more money.

> Atlas Group physician/Restorative Health executive administrator: I think that the business structure is really essential in developing that trust and it's kind of like a house. It's not any different than being at home. The rules don't have to be good, but they've got to be visible and they have to be the same for everyone and I think . . . that that continues to be an element of trust that we're a long ways from getting there in terms of people feeling like . . . somebody's getting special treatment or something . . there's some favoritism going on or somebody isn't understanding somebody. . .

While the ability to share in the profitability in the joint venture was one of the founding principles of Restorative Health, leaders kept that goal and wanted to return to this principle. To that end, as financial reward systems were negotiated in Restructure 2 between leaders of the joint venture, they agreed that physicians would receive financial recognition for their contributions towards the success of Restorative Health and individual contributions to programs beyond their regular work. These financial rewards would mirror individual equity ownership, but would not give them ownership.

> Great Plains University executive administrator: We'll structure compensation arrangements that are pretty consistent.

> Great Plains University executive administrator: Everything would be equal. Like it would be a managed service agreement so whatever people are putting forward to the success of the organization, there would be rewards going out to everybody.

This important change brought greater fairness, equity, and opportunity to all physicians in all parties. According to a Restorative Health executive administrator, through the new incentive plan, each party would decide how to distribute the additional compensation among their members.

> Restorative Health executive administrator: And anything that (the physician) contributes over and above that such as development . . . of new clinic sites or fellowship programs, that there would be additional compensation that would go back to the physicians that would be engaged in that and then Central Health Care could participate in that, too. For

> example, the physician who is our major IT development driver here at Restorative Health is a Central Health Care physician so he in this concept that we've come up with, which actually is Ms .Wilson, she's been the major developer of it, he would also be able to benefit from that or other Central Health Care physicians, but it could go back to the department so it wouldn't probably go back to him as an individual but it would go back to the department and they would say oh, so for Central Health Care' contribution over and above seeing patients, the department itself will get some benefit and hopefully that will also help them feel good about Restorative Health because they can see some additional money coming back to them. The same for the Atlas Group, the same for Great Plains University. So, in a way it mimics equity, in a way, for everybody and (we will) not have differences.

In addition to the new incentive/equity plan that benefited all parties, leaders also changed the base compensation plan during Restructure 2/Negotiation 2. According to a Restorative Health executive administrator, physicians from all parities would receive the same rate of pay through the new plan.

> Restorative Health executive administrator: . . . but we could also have a contract, then, with Central Health Care physicians, as well, so that everybody would be contracted with the Restorative Health clinic and then we would have the basic compensation model that would be everybody who sees patients gets this rate for (unit of measurement), period, that's just the way it is.

Looking back over the five years of the joint venture in this study, administrators and physicians clearly and consistently described three types of financial reward systems: Equity ownership, base compensation, and incentive plans. These formal controls were created and adjusted to shape attitudes and behaviors and administrators and physicians reported that these controls had an overall negative impact on trust.

Organizational Structure

The organizational design which the leaders of the three parties structured and restructured to reach their goals emerged as a second formal control. These control shaped behavior and attitudes and created both positive and negative impacts to trust. Based on

interview data from administrators and physicians summarized in Table 8, structural changes had an overall positive impact on trust over the lifecycle of the joint venture.

Table 8
Impact of Organization Structural Changes on Trust

Stage	Impact of Organizational Structure Change on Trust
Negotiation 1, Design, and Implementation	Restorative Health was created as an "independent place that was a combination of three parties." Power and influence across the three groups were relatively balanced and equal. Overall, trust was high.
Restructure 1	Central Health Care assumed the assets and became sole owner of Restorative Health. Trust was "at an all time low." Some Central Health Care administrators and physicians made the assumption that Restorative Health would adopt all Central Health Care culture, practices, and processes. However, Central Health Care executive administrators chose to keep Restorative Health as an entity and culture separate from Central Health Care. This decision created anger, frustration, and low trust among some Central Health Care executive administrators, department administrators, and physicians.
Restructure 1.1	Central Health Care executive administrators created a new Patient Care service line where both Restorative Health and all Central Health Care physicians reported to the same administrator. Trust increased with some Central Health Care physicians who participate in Restorative Health and continued to decrease among some Central Health Care physicians who did not participate in Restorative Health.
Restructure 1.2	Central Health Care executive administrators disbanded Patient Care service line. Central Health Care physicians who do not participate in Restorative Health report to a separate Central Health Care administrator. Trust increased among both groups of Central Health Care physicians.
Negotiation 2/ Restructure 2	Parties negotiated and agreed to a new structure. The three-party joint venture became a two-party joint venture as Central Health Care owned Restorative Health and Great Plains University managed the joint venture. Atlas Group agreed to be employed by Great Plains University. Overall, trust increased among most parties.

Because leaders from the different parties of Restorative Health originally negotiated, designed, and implemented the joint venture, they created an independent entity that was a

combination of three parties. Power and influence across Atlas Group, Great Plains University, and Central Health Care was fairly balanced. The physicians from Great Plains University and Central Health Care followed a matrix-type reporting relationship and reported to department administrators at Great Plains University and Central Health Care with a dotted-line reporting relationship to Restorative Health executive administrators.

This mix of power and reporting relationship changed when Restorative Health went through two large organization structural changes and two smaller changes within five years.

After the financial crisis, Restorative Health went through Restructure 1 and Central Health Care assumed the assets and became owner of one of the divisions in Restorative Health. For some people, this was remembered as the "the doomsday Halloween verdict" and was a "bitter pill" to swallow. The change allowed Restorative Health to survive financially, but "really changed the nature of the beast" and required that Restorative Health adopt Central Health Care systems and processes. According to some administrators and physicians, the speed of decisions and dramatic changes to the organizational structure had a very negative impact on trust.

> Atlas Group Physician: Public grand opening in the middle of June 2005, whoopty-doo balloons, everybody happy, the public is invited to walk through and, woo, pretty nice. By the Board meeting of this place, by the 3rd week of August of 2005, basically the administration of Central Health Care walked in and said we're upside down financially, we have five choices, the first choice of which…now this is a Thursday evening…the first choice of which is Monday we can lock the doors and say out of business. Totally out of the clear blue to us that it was like wow, wait a minute.
>
> Great Plains University executive administrator: In retrospect, I just think (Restructure 1 after the financial crisis) was done too fast. . . . (The parties) negotiated, therefore the trust was completely blown as a result of that.
>
> Atlas Group physician: I don't think we'll ever know if we had to truly go and reorganize. We were told and the gun was held to our heads saying that has to happen or Restorative Health's going to go belly up. So that destroys your trust right there.

> Central Heath Care physician: One of the things that had to be totally redone was after a year, we had to reorganize and that set us back in terms of trust because there were threatened lawsuits by the Atlas Group.
>
> Central Health Care administrator/physician: . . . each group was kind of looking at its own thing, so, well, things started to go south . . . it was kind of everybody was kind of out for themselves.

For some physicians and administrators at Central Health Care, Restructure 1 was initially perceived very positively. Because Central Health Care stepped in and saved Restorative Health, some Central Health Care administrators and physicians believed that Restorative Health would automatically adopt the Central Health Care culture since Restorative Health was also moving on to the Central Health Care technology and Human Resource systems and processes.

> Central Health Care administrator/physician: . . . my initial thought, being a Central Health Care physician, was sweet, we can make whatever decisions we want now because (Central Health Care) won this division of Restorative Health, we're in charge.

However, frustration increased and trust decreased among some Central Health Care administrators and physicians as they came to realize that Restorative Health would retain their individual culture and business model separate from Central Health Care.

> Restorative Health executive administrator: . . . (my) charge (from Central Health Care executive administrators) is make Restorative Health successful. That was pretty clear that should be my top priority which further outraged the vocal minority and the Central Health Care physician department because they felt that their organization was paying too much attention to Restorative Health at the expense of their interests.

While the structural changes made at this time helped to stabilize Restorative Health, the three parties continued to struggle to work together. As a result, leaders of the joint venture implemented Restructure 1.1, another structural change, and created the Patient Care line of business within Central Health Care. Under the Patient Care line, all physicians from each of the three parties that participated in Restorative Health and the Central Health Care physicians who

did not participate in Restorative Health reported to the same department administrator at Central Health Care. This change had some success, but issues of trust, equity, and teamwork persisted. According to some Central Health Care administrators and physicians, the organizational changes in Restructure 1.1 made the situation worse, not better.

> Central Health Care administrator/physician: . . . when (Central Health Care executive administrators) formed the Patient Care service line, they took non-Central Health Care people and made them the Patient Care service line leadership. Totally blew up all of the concerns and frustrations of the (Central Health Care) physician department. (Central Health Care people who did not support Restorative Health) who were naysayers now are screaming even louder. They're like the only thing the organization cares about is Restorative Health; nobody cares about us, the people over here.
>
> Central Health Care administrator/physician: . . . what proceeded or succeeded over the next two to three years, as Dr. White and Ms. Mathews were doing this, was, I think an even worsening rift between Central Health Care physicians and what happened at Restorative Health. . . . So, the hostilities and divisions, if anything deepened when that happened.
>
> Central Health Care administrator/physician: . . . I'm sorry to tell you this, but I really don't think (the Restorative Health partnership) is very cohesive. I think it's complicated.

From these changes, physicians and administrators reported mixed results. Thus, in another attempt to address and overcome issues of trust and teamwork, executive administrators implemented Restructure 1.2, a second minor structural change. The Patient Care business line was disbanded so that Central Health Care physicians who worked in Restorative Health and Central Health Care physicians who did not work at Restorative Health now reported to separate Central Health Care administrators. According to Restorative Health executive administrators, by making a change so that the physicians who supported Restorative Health and the physicians who did not support Restorative Health reported to different administrators would help to better leverage the synergies of the two groups.

> Restorative Health executive administrator: When I could see that the Patient Care business line was not working, I approached Dr. Baker, (department administrator at

> Central Health Care) and explained why I wanted to move Central Health Care physicians back to his service line – to be able to get more synergies by the Central Health Care physicians reporting to Dr. Baker.
>
> Ms. Matthews: Dr. Baker, who is the VP over surgical service and I get along really, really well and so I went to him first and said Dr. Baker, I'm proposing…I'm going to propose to Central Health Care executive team to switch out Central Health Care department administration to you and I talked to him about it first and he said yeah, he was okay with that and he understood why I was doing it. And so I said Dr. Baker, you and I are going to be able to partner a lot more easily to get synergy than them reporting to me.

Some Central Health Care administrators and physicians acknowledged that trust had decreased with changes in Restructure 1 and 1.1 and supported the organizational changes of Restructure 1.2.

> Central Health Care administrator/physician: We just became more and more and more and more disenfranchised with this whole service line thing to the point where . . . the Patient Care service line does not exist anymore.
>
> Central Health Care administrator/physician: . . . there are differences and the differences haven't gotten any better. If anything they've gotten worse. So, we all agreed that we think it's beneficially really to everyone to not have a Patient Care service line and to just simply recognize that Restorative Health is separate; it's its own entity. . .

From this change, Ms. Matthews was able to make progress with her ideas as she worked well with Dr. Baker, the new Central Health Care department administrator. By working with Dr. Baker, Ms. Matthews was able to gain greater support for Restorative Health efforts from non-Restorative Health participating Central Health Care physicians.

> Ms. Matthews: . . . (the Central Health Care physicians who did not join Restorative Health) can look to Dr. Baker as the leader and he and I would then collaborate and he can go back to them and say you know guys, this makes a lot of sense to me. If they weren't hearing it directly from me, I think they can accept it because they don't see Dr. Baker as having an agenda for Restorative Health.

While the structural changes from Restructure 1.2 created some progress and improvements, trust, equity, and teamwork issues continued to exist between some physicians and administrators. As a result, leaders agreed that discussions should resume. According to a

physician and administrator from Central Health Care, the focus of these discussions were to consider how best to return to the original vision and structure of a three-party joint venture with balanced power and influence and provides benefits for the individual physician.

> Central Health Care administrator/physician: . . . now what we're doing is trying to get back to the original vision of this place which is a three partner group, separate from the mother ship, if you will, Central Health Care, that is truly an independently run place that benefits based on the individual nature of this place.
>
> Central Health Care physician: . . . I think that if you looked at what has happened with (Central Health Care) departments and Restorative Health, where we are right now is to a large extent because of mistrust and unhappiness with the way things have evolved and that is that Restorative Health and the (Central Health Care) department of physicians became a single service line separate. We used to be under (another service line), then the Patient Care service line, which Restorative Health was separate. Now (Central Health Care physicians are) back into (original service line). Restorative Health's separate on its own. So that to me speaks to this whole notion of the lack of trust and feeling of alienation, if you want to think of it that way.
>
> Central Health Care physician: It's not part of our fundamental multi-specialty group thought process and that sort of thing and so what's sort of part of this disillusion of the service line, it lets Central Health Care department say let's put this behind us and let's go figure out what we want to do and it lets Restorative Health be recognized because we're different than Central Health Care Clinic and we do things differently here and this is our little corner of the world and we don't really have a formal affiliation with Central Health Care department anymore other than the fact that Central Health Care physicians work here.

Over several months, leaders from the three parties met and negotiated Restructure 2, a new structure, which would meet the needs and would be acceptable to all parties. Under the new structure, the three-party joint venture changed to a two party joint venture. Restorative Health was now owned by Central Health Care and managed by Great Plains University. Atlas Group physicians reported to Great Plains University and Central Health Care was the owner of Restorative Health. In addition, through this change, Restorative Health became a non-profit subsidiary of Central Health Care and physicians from Atlas Group and Great Plains University signed a long-term contract to be managed by Great Plains University. According to an

executive administrator at Great Plains University, the leaders wanted to implement this change in the organization's structure correctly and not repeat some of the mistakes that damaged trust in Restructure 1.

> Great Plains University executive administrator: . . . so we're now at the point of trying to structure something that will meet regulatory issues and try to meet everybody's interests. And I think (the Atlas Group) is reluctantly there. I think that there is more trust, that it has been developed.
>
> Great Plains University executive administrator: . . .(Restructure 2 is) about building trust, bringing people along so that we structure it right and everybody goes in with a full understanding about it..
>
> Atlas Group physician: I think there have been things done all the way along that have continued to batter at the trust that I have for (Central Health Care). Now, there's a suspicion I'm not confident that we're going to get the reorganization done and so I have to come here and trust that their motives are directed back towards pure motives. I haven't seen that over five years, necessarily and you know, I'm looking at it from a partner here who is "wounded" by the vision going away and now we're trying to put it back together in a different manner and the players who we're working with are different, okay? So the people that I absolutely came to mistrust are gone from the Central Health Care system and that was the CEO there and the CFO, so and now there are different people running the show who I think get it and understand what we're trying to do here and it looks to me like they are trying to get this back to what we originally envisioned.

In summary, founders and leaders of Restorative Health set out to design an organizational structure for a joint venture that would create a unique vision, mission, and culture. When internal and external forces unexpectedly changed, the leaders made changes to their organizational structure that acted as a formal control and allowed the joint venture to survive. Also, as a type of formal control, changes to the organizational structure had an overall positive impact because individuals' attitudes and behaviors were shaped and the joint venture overcame several internal and external forces.

Selection and Placement of People

Over the life of the joint venture, the selection and placement of several specific individuals into key roles was a formal control that had an overall positive impact as Restorative

Health evolved and adapted. As the following quote illustrates, without specific individuals and the roles they played at the specific point in time, the joint venture would have ended with a different outcome.

> Central Health Care executive administrator: . . . there are a number of people that could have killed that project at any time and if it wasn't for a core group of people (Restorative Health) wouldn't have happened.

There were several individuals playing critical roles in the success of the joint venture. To illustrate the importance of the selection and placement of key personnel as a formal control, I will provide an example that focuses on Dr. White, his significant contribution and the resulting impact on trust over the different stages of the lifecycle. Table 9 describes Dr. White's significant contribution and the resulting impact on trust over different stages of the lifecycle.

Table 9
Impact of Select and Placement of Dr. White on Trust

Stage	Impact of Selection and Placement on Trust
Negotiation Through Restructure 1	Dr. White held the vision and was the "driving force" behind the joint venture for Great Plains University. During the early stages, he earned the trust and respect of people and gained leadership's support from Great Plains University for Restorative Health.
Restructure 1.1 and 1.2	Central Health Care executive administration selected Dr. White to lead the Patient Care service line because of his knowledge, skill, and reputation as a physician, administrator, and peacemaker in bridging the three groups. He listens to understand everyone's perspective and facilitates communication and teamwork.
Overall	Dr. White has high integrity and puts the interests of the overall entity first above one specific partner. He is visible with the groups and takes time to listen to individuals. Through these attributes, Dr. White forged trust with most people.

Negotiation Through Restructure 1. As stated in the Introduction section of this chapter, Dr. White met with Dr. Scott before Dr. White accepted his starting position at Great Plains University to discuss the business concept of a joint venture. Once hired in his position as

a department administrator at Great Plains University, Dr. White worked hard to gain the trust and win support from university leadership for the joint venture. According to an Atlas Group physician, Dr. White became the *"the driving force"* at the university for Restorative Health. In addition, a physician and executive administrator at Central Health Care stated that people were willing to join the joint venture because they trusted Great Plains University because they trusted Dr. White as they came to know his character.

> Central Health Care executive administrator: (Dr. White) carried a lot of weight and respect and he had a very strong interest in the concept . . . he was a cheerleader of (Restorative Health), he was a proponent of it and he did a lot of work to get docs on board and led his team, the Great Plains University, he had to go to bat for Restorative Health for the University leadership.

> Central Health Care physician: . . . as far as trust goes, I think there was a lot of trust with regard to the University. I think in large part because Dr. White was involved and everybody felt that Dr. White was and is a very honorable person with a lot of integrity and so there was no question about his individual issues.

Restructure 1.1 and 1.2. As executive administrators at Restorative Health and Central Health Care worked to rebuild morale following the Restructure 1, they made an important decision when they hired Dr. White to lead the newly created Patient Care business line at Central Health Care. As described earlier in this chapter, Dr. White was selected for the position at Central Health Care because "it was determined that Dr. White would probably be able to bridge the three groups better than anybody else." According to a Restorative Health executive administrator, outcomes could have been very different if someone other than Dr. White had been selected for the position.

> Restorative Health executive administrator: I don't know what would have happened to Restorative Health (if someone other than Dr. White would have been hired for the position). He was definitely the most even-keeled, very thoughtful, he can deal with conflict . . . he tends to be able to manage the agendas of all parties. He can see everybody's point of view. He's very fair.

Overall. Through the early stages and through the restructuring stages, the selection and placement of Dr. White into leadership roles proved to be a wise decision. People grew to trust him because they saw he was neutral as an executive administrator at Restorative Health and did not stand to "gain from a personal perspective" from the joint venture. According to Dr. White, people trusted him because he was transparent, a peacemaker, and took time to understood people and their interests.

> Dr. White: I'm transparent, straight-forward. I work as a doctor as much as anyone else does. People respect me. I don't play political games.

> Dr. White: I'm the peacemaker. . . I think that is why I have the position of peacemaker and trusted confidant is because I've put the interest of the entity first, always, rather than the interest of one partner over the other. Even when I was not the CEO (of Restorative Health), I did that and that's how I was given the position is because I was trusted.

> Dr. White: I understand why Central Health Care. . . why they made decisions that they made and there's more trust between me and Central Health Care than there is between a lot of the Atlas Group docs and Central Health Care, in part because I've spent more time with them and have seen the way they behave and what their motives are…

Dr. White's character traits that he described above earned others' trust and were echoed by the people he worked with on a physician and administrator level.

> Great Plains University executive administrator: . . . (Dr. White) would just spend a lot of time, he was very visible there, just trying to find neutral ground with the Atlas Group and our docs.

> Central Health Care executive administrator: . . . I have a lot of trust in Dr. White. Today, I still do. . . Dr. White, first of all had a lot of credibility as a physician, he had a lot of respect in lots of organizations and within his specialty, but I got to like his thought process, his thoroughness and he was a guy that would do what he said and he was honest, straight forward and had a lot of integrity. . . He's pretty good at trying to be the facilitator of discussions and to mediate certain things.

> Central Health Care physician: . . . on a personal level, Dr. White's integrity is beyond question and I think that that really helped forge trust.

In conclusion, the selection and placement of several specific individuals into key roles became a formal control that had an overall positive impact for both physicians at Restorative

Health and physicians who chose not to participate in the joint venture. Without these individuals, the outcome at the end of the joint venture could have been different. The example shared above of Dr. White was illustrative of a larger pattern, where leaders intentionally selected and placed several people in positions and where participants in the study reported that the people in these roles made a significant and positive impact on the members of the joint venture.

Conclusion

In Chapter 5, I described three themes that emerged on the roles that formal controls play in influencing the establishment of trust during each stage of a joint venture. These formal control themes derived from interpretive interviews were financial reward systems, organizational structure, and the selection and placement of people in the joint venture. Changes in financial reward systems were perceived to have an overall negative impact on trust, changes in organizational structure were perceived to have an overall positive impact on trust, and the placement of leaders in the joint venture were perceived to have an overall positive impact on trust.

Chapter Six

RESULTS – INFORMAL CONTROLS

As explained in Chapter 5, leaders identified several formal controls that they used to shape attitudes and behaviors. In this chapter, I will describe the informal controls that leaders identified and how leaders also recognized that informal controls could have a more valuable impact on shaping attitudes and behaviors than formal controls. According to a Restorative Health executive administrator, informal and implicit controls were needed to hold the joint venture and the partners together.

> Restorative Health executive administrator: Yes, we had written policies, but if you're talking about not having the individual parties scream and yell at one another during this phase, that never, we never had to be explicit about that because the doctors were smart enough to realize that if we scream and yell we're going to blow this thing up and we've already tried every other mechanism to get this thing done and now we've got a good partner.

To gather data on Research Question 2 and discover insights into the roles of informal controls and how these controls changed over the lifecycle, I asked participants questions and listened for clues to answer two main questions:

a. How were informal controls (i.e., norms, shared values, personal relationships) used during the negotiation, commitment, and implementation stages of the joint venture?
b. How did a reliance on informal controls change over the lifecycle of the joint venture?

In Table 10 below, I describe the code families and sub-code families according to the lifecycle stage of the joint venture where the control developed or changed as reported during my interviews.

Table 10
Informal Controls Code Family and Code Sub-family

Code Family	Code Sub-family	Quotes within Sub-Family
Design	Development/Change in Informal Controls	6
Negotiation	Development/Change in Informal Controls – Allow input from others, buy-in, support	5
Implementation	Development/Change in Informal Controls	6
Restructure 1	Change in Informal Controls (commitment and passion for vision, communication, and relationships to build support.	13
Restructure 1.1	Change in Informal Controls – Feelings of resentment and negative information from external physicians	34
	Change in Informal Controls – Relationships, optimism	6
Restructure 1.2	Change in Informal Controls – physicians offering to help each other	6
Restructure 2	Change in Informal Controls – Relationships	8

Based on these family and sub-family codes, three types of informal controls emerged: compelling vision/mission, relationships between leaders and physicians, and buy-in/support. These informal controls and summarized in Table 11.

Table 11
Summary of Informal Controls and Impact on Trust

Informal Controls	Description of Change and Impact on Trust
Compelling Vision/Mission	In general, leaders and physicians of all three parties formed and pursued a consistent and compelling vision/mission over the lifecycle of the joint venture. Trust among the leaders of each party formed quickly around the common belief in the vision/mission and this trust continued as the parties endured the hard times and forgave others' mistakes.
Relationships	While relationships and trust between the founders remained strong throughout the joint venture, relationships and trust between other individuals struggled over the lifecycle. Some relationships were positively impacted as administrators and physicians worked together and came to know each other and as individual genuinely helped each other without expectation of reward or return. In contrast, some relationships were negatively impacted as some administrators and physicians avoided referring patients to Restorative Health and held an "us versus them" mentality. Through these attitudes and behaviors, relationships as an informal control had a positive and negative impact on trust.
Buy-in/Support	Buy-in and support from administrators and physicians for the joint venture became an informal control that had a positive and negative impact on trust. After Restructure 1, people within the three parties demonstrated their level of buy-in/support that ranged from strong support to strong opposition.

The following section describes how these three informal controls changed over the lifecycle of the joint venture and how the controls impacted the development of trust.

Compelling Vision/Mission

The formation and pursuit of a compelling vision and mission for Restorative Health emerged as a key informal control in the development of trust and success at Restorative Health. As described in Table 12, this vision and mission played an important role during the Early Stages (Negotiation, Design, and Implementation), during the Recovery Stages (Restructure 1, 1.1, and 1.2), and into the Future Planning stage of Negotiation 2/Restructure 2.

Table 12
Impact of Compelling Vision/Mission on Trust

Stage	Impact of Compelling Vision/Mission on Trust
Early Stages	Each party entered Restorative Health with different interests and expected benefits from the combined vision/mission. Beyond just making money, the Restorative Health vision/mission was to create a Center of Excellence as a great place to work, great place for patients, a great place for community education, and a great place for educating physicians. This vision/mission was relatively easy to agree upon and support which allowed trust to grow among administrators and physicians in each party.
Recovery Stages	After the financial crisis and during the multiple stages of restructuring, people's commitment to the vision/mission passed through extreme pressure and tests. As a result, the vision/mission as an informal control created negative and positive impacts on trust. Negative: While some administrators and physicians from all three parties acknowledged that they shared a common vision, some believed that their different backgrounds and cultures were too diverse and too extreme to effectively work together. These differences were manifest as some Central Health Care administrators and physicians performed their work for Restorative Health, but continued to work according to their Central Health Care mission/business model. As a result, trust among administrators and physicians across the three organizations was negatively impacted. Positive: The strong belief in the compelling vision/mission allowed people to recognize that Restorative Health would not be the same without the unique strengths that each party brought, forgive people's mistakes, overlook offensive personalities, and endure hard times. Through these struggles, people continued to believe in the Restorative Health vision/mission and the joint venture gradually recovered until it became stable and gained market share by leaps and bounds.
Future Planning Stage	As the parties reflected on the past and looked to the future, they felt great satisfaction in their vision/mission. They overcame extreme tests and challenges to their vision/mission and made significant progress towards reaching their vision/mission. The realization and optimism that Restorative Health would succeed in the future and against new competition had a significant positive impact on trust.

Early Stages. According to the Atlas Group physicians, one of their driving interests to form a joint venture was to find a way to use their medical practice as a business venture that would continue on after they stopped practicing medicine.

> Atlas Group physician:. . . there's nothing deader than a dead doctor, which meant that you guys are in a tough spot when you sit down across the table with somebody that's got money because you bring…you don't bring a business, you bring the practice to the table but not your business.

> Atlas Group physician: . . . we . . . had the concept that somehow, medicine, even a group practice, could become a real business . . . by being a real business ideally this business ought to be able to capitalize itself. It should be able to retain earnings for growth. It should be an investment vehicle for everyone . . . involved in the company.

Beyond simply making money and earning revenue, the Atlas Group physicians and leaders from the other two parties envisioned Restorative Health as a great place for both patients to receive care, for physicians to work, for new physicians to be educated, and as a benefit for the entire community. This shared belief in the vision is described below by an Atlas Group physician.

> Atlas Group physician: You can wrap your hands around all those revenues, but in the long run our belief was that the legitimacy of this center of excellence is derived from a great place to work, a great place for patients to come and more importantly, a great place that's a leading center for community education, for educating physicians at all levels, and, you know, gives something back. Because if it's just a medical center to enhance the physicians profitability, we didn't think that was the right way to go. And that wasn't our goal. Our goal was to…we've always believed in research education or an education of fellows and residents and felt that there was a role for the revenues to support that from a center.

Getting agreement from administrators and physicians across the different parties was relatively easy and each party could envision the strengths that each party would bring and receive. According to an Atlas Group physician and Great Plains University executive administrator, rallying around the vision/mission in the early stages of Restorative Health was easy and built trust among the parties.

> Atlas Group physician: . . . and so the negotiations were easy on the trust factor because we all believe in the same goals and it was easy for everybody to sit at the table and say that's a great idea. So that fit right in the wheel house.
>
> Atlas Group physician: Central Health Care again appeared to be the source of a lot of the pro forma, that's where the patients were going to come from. They had captured patient population, they had a large medical department, and they could use an expansion in some of their resources, so it kind of all looked really good. So everybody was feeling pretty good.
>
> Atlas Group physician: Well, (the Atlas Group physicians) worked together, most of us, for 15 years or more as partners and we had continued to…we just all shared this vision and we weren't going to let anybody say no to us and so after all the meetings and all the time and all the money that we spent to get this thing done, it was…we were in this up to our eyeballs together.
>
> Great Plains University executive administrator: . . . the trust among the founders was that they spent several years around this visioning of what they wanted to build and it really . . . it became a reality and it worked in every way except financially.
>
> Great Plains University executive administrator: . . . I mean everybody had the vision, so it's not just a few people.

While the Restorative Health vision/mission was compelling and united people moving their compelling vision/mission from an idea to reality proved to be difficult. This challenge in translating vision/mission into concrete details was described by an Atlas Group physician.

> Atlas Group physician: The goals are right there on the wall and we all agreed to those easily. That was some of the easiest stuff of this whole thing. What's the vision? What's the vision statement? That's easy to do because it's easy for everyone to say yeah that's a great idea. The minute to minute application of those…like they always say, the devil's in the details. Details get interesting.

Recovery Stages. From some people's perspective, the financial crisis and subsequent restructuring "took the wind out of the common sails" and caused the Restorative Health vision/mission to pass through extreme pressure. As a result, the compelling vision/mission of Restorative Health continued to be an informal control with negative and positive impacts on trust.

According to some administrators and physicians from the different parties, they acknowledged that while they shared a common vision, they also believed that the different backgrounds and cultures of their parties were too diverse and too extreme to effectively work together.

> Central Health Care administrator/physician: So you bring in these three groups, one is an entrepreneurial free-standing single specialty practice, you bring in a university with a socialistic operating mentality where a lot of things are shared and an altruistic research and education desire and then you bring in this multi-specialty group with its own descriptors that you can apply in a variety of ways but what I would basically say is that a multi-specialty group like this tends to attract physicians that are interested in practicing high quality medicine, but don't want to put the leg work into building a practice and managing a business. That's a huge difference from the first group. So we had these three partners who had a certain common vision, but their backgrounds were so diverse that it was . . . the extremes were too big to make it really come together nicely and that's again if things had gone fine we would have been all right if everybody was making money, but when we weren't making money, then all those differences. . . the common vision goes away and all the differences come to the surface.

> Atlas Group physician: What we come to the table for is to try and continue our vision of providing excellent care to continue to support the education and research on into the future, to expand programs into other interesting areas like our new women's program, that type of thing, and to be able to do that and to have resources to accomplish those difficult goals. And so it was sort of three very disparate, very culturally different groups who landed here together because the culture of those three systems is enormously diverse and enormously at odds. Still.

According to a Great Plains University physician, these differences in vision/mission were manifest as some Central Health Care administrators and physicians performed their work for Restorative Health, but continued to work according to their Central Health Care mission/business model.

> Great Plains University physician: As a Central Health Care person comes into Restorative Health, they have to buy into the philosophy that we're trying to deliver a different brand of medicine here and these guys don't think that, as far as I can tell. They just look at it as another place to work and make money and the more money you make, the better it is. . . I've heard two of them say personally to me that they really don't care how long people have to wait to see them and that Central Health Care patients should only be seen by Central Health Care physicians because that's the way it is even if they

> have to wait six of seven weeks, rather than seeing somebody else at Restorative Health who could be seeing the patient in a shorter period of time.

While each party had different reasons for joining the joint venture, any one of the parties could have left the joint venture at any time. However, while some administrators and physicians believed the backgrounds and goals of the three parties were too diverse and extreme for achieve the Restorative Health vision/mission, others believed the vision/mission and concept was strong enough to keep the parties together.

> Central Health Care executive administrator: (Any one of the three parties) could have left. Individually they could have left or as a group they could have left and said you can have my investment I'm out of here . . . we had different reasons for coming together. Maybe different motivations for coming together, but the reason to do this and the concept was still (strong enough).

Amid the challenges individuals and parties experienced during the restructuring stages, the leaders worked hard to hold up the common vision and mission to inspire people to overcome the barriers they faced. This use of the vision/mission as an informal control positively impacted trust. According to a Restorative Health executive administrator, asking the parties to keep the original vision in mind helped them forgive each other's mistakes and persevere through the hard times.

> Restorative Health executive administrator: The vision that it was the right thing to do for patients. The basic gut feeling was that we had the right ideas.

> Restorative Health executive administrator: It's worth it, remember the original vision, remember why we did this in the first place, (specific physician who made a mistake) is really not a bad guy . . . he just had a bad day, he didn't mean that.

Tests to the strength of the Restorative Health vision/mission continued as some Central Health Care administrators and physicians tried to pressure their executives to force Restorative Health to relinquish their vision and mission and adopt the Central Health Care culture, vision, and mission. However, Central Health Care executives did not comply. According to a Restorative Health executive, the Central Health Care administrators and physicians who did not

embrace the Restorative Health vision/mission could not understand the unique combination the three parties created a how this value and increased market share would be lost without the Restorative Health vision and mission.

> Restorative Health executive administrator: I think it was kind of hard for (Central Health Care executives) because there was so much push back inside (their) organization about acceptance of who Restorative Health was or why Central Health Care don't just put the Central Health Care name on the (Restorative Health) building and be done with it and I'd say because you won't have the same kind of translation into increased market share and all the things that Restorative Health was created for and we'd lose the partners and we can't be as successful if we don't have Great Plains University and the Atlas Group in the mix.

> Restorative Health executive administrator: (Restorative Health) has got a life of its own now and it's creating a great place for people to work and for patients to receive care and for residents to be trained, etc. and it's unique. It's very unique. And that each partner has a role in making sure that it can continue because it won't. If any one of the partners didn't stay engaged, it won't.

> Restorative Health executive administrator: I knew I had to hang on to the people (who embraced the Restorative Health vision/mission) and so I worked really hard to maintain the vision and the optimism and we're going to get there and you guys are going to get us there because you are Restorative Health, because we're Restorative Health. We created it. It's us and if we leave we can't guarantee that it's going to be what we've worked so hard to create, but now we've got to make sure that it's sustainable.

> Restorative Health executive administrator: Lots of people had to be flexible, there was lots of creativity. People were willing to do it because they believed in the vision.

In addition to push back from some Central Health Care administrators and physicians, the personalities of some physicians became offensive to each other during the restructuring stages. According to a Great Plains University executive administrator, while these conflicts could have caused some parties to quit the joint venture, the compelling vision/mission of Restorative Health and people's commitment to this vision/mission held people together.

> Great Plains University executive administrator: I mean, some of (the Great Plains University physicians) don't like the Atlas Group docs. There are personalities in that group that are offensive and we just have different motivations for why we work. The thing that kept everybody together is everybody really did have this vision for delivering outstanding, cutting edge patient care.

Thus, through the conflict and struggle of Restructure 1, 1.1, and 1.2 to become stable and profitable, the vision/mission Restorative Health became an informal control that negatively and positively impacted trust.

Future Planning Stage. As the parties reflected on the past and looked to the future, they felt great satisfaction in the vision/mission they created and followed. Their vision/mission passed through extreme tests and challenges and they made significant progress to reach their vision/mission. According to physicians and administrators, this realization renewed people's belief in the vision/mission, strengthened their optimism that Restorative Health would continue to succeed and meet new competition in the marketplace, and had a significant positive impact on trust.

> Atlas Group physician: I think that vision was hammered out over time. We floated the vision. We were the people who saw that and felt that if we were going to do this the way we wanted to . . . have a first class facility, a single specialty facility that only did (our medical specialty), that was the best, identified as "the" center in town for medical care and that vision has come to a fruition in spite of all of the naysayers who couldn't jump on board with us and we had a lot of people laughing at us, thinking it would never happen and it's happened and it's changed the dynamics of the market and so it's kind of nice to step back and say you know, this was a good idea, this has been successful, this has continued to grow and continue to be successful. So I think we brought like-minded people who were willing to share the vision, willing to invest time, energy, effort, and money in a venture like this, so it wasn't without a risk for all partners involved. But I think we all saw the common vision and saw an opportunity here to do something special.
>
> Atlas Group physician: (Restorative Health) is the place identified (in our vision/mission), it's very, very…it's very rewarding that this vision that we had is the specialty center in town that people identify where they go for their health care. Now, there's lots of other really good doctors in town but nobody has what we have here at Restorative Health and the whole concept. And so I'm proud of the fact that's our vision.
>
> Central Health Care administrator/physician: But I think (Restorative Health) still has the opportunity to get there and I'm optimistic that it will because the goal is a laudable one that everybody believes in, it's just a hard time getting there.
>
> Restorative Health Care executive administrator: . . . we will continue to succeed, despite what other (competing health care organizations) are trying to do, and that' s because of the foundational vision that we have, the mission that we have, that they don't have.

> Their mission is making money. . . . The groups that are trying to copy what we've done and (making money) is no mission that will get people to collaborate. It's just not important enough. . . (Restorative Health) has a mission. We want to make medical care easier and less confusing and more accessible for everybody, even if it means doing it for less.
>
> Central Health Care executive: . . . I'm proud to have been able to help fashion that idea into a reality. I'm proud of the fact that we overcame some big obstacles to create a joint venture of three different cultures and I'm proud that it stuck together and didn't close up, even with some adversities. And I'm proud of the fact that I had some role in that and I'm really pleased that I made a lot of good connections and contacts there and good friends in the process, docs, administrators, all across the board.
>
> Great Plains University executive administrator: (The founders of the joint venture) really stuck to the vision. They never lost sight of what it means to be cutting edge medical care. Fabulous experience for patients, great facility, cutting edge research that's done there because there is some research space. I would say that was the factor is that they never wavered from the vision and they had physician leaders that kept that in front of people. And you don't always see that. I mean, Dr. White, he's got his elevator speech. Ms. Matthews has her elevator speech. They really kept on message. I think that was a real positive thing.
>
> Great Plains University executive administrator:. . . at the end of the day, no matter about the disagreements about the business arrangements, I think people feel this great sense of pride about what they've created from a care model, from a patient experience standpoint, from an employee satisfaction standpoint, I think they all feel really good about it.

The compelling vision and mission of Restorative Health was an important informal control in the success of the joint venture and the evolution of trust. The vision and mission of Restorative Health was to create a Center of Excellence that was different from traditional health care services and to do more than make money. In the early stages, trust was high as the vision and mission were clear and easy for leaders from all three parties to embrace. Following the financial crisis and during the years of restructuring, the vision and mission passed through extreme tests. As "trust was battered," physicians and administrators learned to forgive each others' mistakes, overlook personality differences, and endure the hard times because they firmly believed in the compelling Restorative Health vision and mission. Once Restorative Health

became stable and profitable, leaders felt great satisfaction in the vision and mission they created and pursued and looked to the future with renewed confidence and optimism. Through the compelling vision and mission, leaders from all parties were united and inspired which informally contributed to the evolution of trust over the lifecycle of the joint venture.

Relationships

Relationships between individuals and parties emerged as a second important informal control in the success and in the evolution of trust within Restorative Health. When Restorative Health was first formed, some believed that relationships between the three parties would automatically meld and trust would automatically grow. However, according to a Central Health Care administrator/physician, these desired relationships between the parties melded to some extent, but rifts developed and kept others apart.

> Central Health Care administrator/physician: . . . the idea was over time we'd all just sort of integrate ourselves and blend and mesh in, but that just has not happened. And it has for some people. There have been some Central Health Care physicians who have sort of melded in more, but there still is a deep rift between different groups.

As described in Table 13, some relationships created positive impacts on trust over the Early Stages, Recovery Stages, and Future Planning stage, while other relationships resulted in a more negative impact on trust over the lifecycle of the joint venture.

Table 13
Impact of Relationships on Trust

	Early Stages	Recovery Stages	Future Planning Stage
Positive Impact on Trust	Early relationships between Atlas Group physicians, Dr. White, and Central Health Care executive administrators were strong and grew in strength throughout the lifecycle.	Physicians learned about each other and worked together. Administrators and physicians genuinely reached across party boundaries to help each other without expectation of reward or return.	Restorative Health executive administrators renewed and strengthened prior relationships with new Central Health Care executive administrators.
Negative Impact on Trust		Poor relationships between some Central Health Care administrators and physicians and some Atlas Group physicians created a negative impact on trust. Some Central Health Care administrators and physicians did not view some Atlas Group physicians as playing on the "same team." As a result, some Central Health Care physicians did not refer patients to Restorative Health and complained about delinquent behavior of physicians outside of Central Health Care while their own physicians had some of the same delinquent behaviors.	

Relationships Positively Impact Trust. Evidence of relationships as an informal control with positive impacts on trust was seen in the relationship between Dr. White and the Atlas Group physicians. From the time Dr. White first became a department administrator at Great Plains University, met the Atlas Group physicians, and worked with them through Restructure 2/Negotiation 2, their relationships were strong. This relationship was strengthened as they worked together to search for a third-party to join the joint venture. Once Central Health Care agreed to join the Restorative Health, relationships were equally strong between Dr. White, the Atlas Group, and Central Health Care executive administrators as they worked together during the Negotiation 1 and Design stages. During the Negotiation 1 stage, relationships among leaders and administrators were strong as each group recognized and appreciated the unique strengths that each group brought to the joint venture.

Shortly after Restructure 1, some relationships between individuals and parties became strained and required leaders to invest considerable time and action to rebuild the relationships and trust. According to a Great Plains University physician, their relationship and trust with Atlas Group physicians increased as they learned about each other and worked alongside each other.

> Great Plains University physician: I think the relationship between the current Atlas Group and Great Plains physicians has never been bad. . . I think that by being at Restorative Health, we've learned more about each other and we've probably added to that original trust basis and I think that it's made the relationship between the two groups better. I don't think the relationship was ever very bad. It just made us know each other better and know what we're good at and vice versa. That goes both ways.

In addition, several physicians described examples of how relationships and trust were positively impacted during Restructure 1.1 and 1.2 as physicians and administrators reached out and willingly and genuinely gave help and assistance to each other without expectation of financial reward or reimbursement.

> Great Plains University physician: . . . I think that (Central Health Care physicians) are recognizing (that Great Plains University physicians) are very helpful . . . (Dr. Tyson) goes in and helps people all the time with medical procedures . . . he helps a lot of their medical specialty (cases) . . . he helps them and a lot of times they're not ever sharing the cost of medical procedure. He just does it to be a good guy . . . I do think that we are changing things and we are available for questions. We are available for questions, we have curbside counsels all the time, I have people email me, they email Dr. Young. And then Dr. Tyson, of course, they use heavily. Dr. Williams they use heavily. He's an expert in his specialty so I think that just by being there, we've allowed a sort of higher brand of medical knowledge base.

> Central Health Care physician: (Dr. White) volunteered as a show of good faith to take call at Central Health Care with our group, even though he didn't need to do that. There was no reason that he had to, but he takes calls with us and you know that's more work. So, I think things like that have really helped. The leadership of the Atlas Group, we're really just talking about five physicians, they, I think, have, from my perspective engendered trust because they have made us realize that they are in this to make it work as much or more than anybody else. So I think that they've shown by example just how they work and by their passion that they're committed. And I think for me, at least, that's spelled trust.

> Central Health Care physician: I think as (Atlas Group physicians) got to know me, for example, they knew that I was here to try and make this as good as it could be. That I wasn't a warm body and I'm sure that this has contributed to the trust as well. Plus, someone might call me and say could you see (high profile patient) and I'd get him in and I'd treat him like anybody else. I wasn't going to turn anybody away. So, I think that it was trust both ways.

As Restorative Health became stable and profitable, success and growth really accelerated. Not only were day-to-day operations running smoothly, but physicians and administrators received positive feedback from patients. As a result, the success of the three-way partnership snowballed. According to a Restorative Health executive administrator, amid the growth and success, people could sense that relationships were improving again, which was a turning point in the joint venture.

> Restorative Health executive administrator: . . . I think as we became more and more successful, when the growth took off and the brand stuck, all of a sudden, I felt like that because things were going so well on a day-to-day basis and the patients loved us and the feedback started coming in, things started really turning again and the partnership started to evolve into something that was now going to . . . I could tell, the relationship started improving again. So that was a real critical moment.

By the time Restorative Health moved out of the Recovery Stages and entered the Future Planning Stage, all three executive administrators at Central Health Care had left Central Health Care and were replaced by internal administrators. According to a Great Plains University physician, this change in leadership required work by Restorative Health executive administrators to re-build and renew positive relationships with the new generation of leaders at Central Health Care.

> Great Plains University physician: Most of the people that I worked with in Central Health Care are now gone . . . everybody that I knew from an administrative standpoint at Central Health Care is now not there anymore . . . the people who helped create Restorative Health other than Dr. White and Dr. Scott, really are not a major player in Central Health Care anymore so you have to kind of re-excite Central Health Care as to who (Restorative Health) is and why (Restorative Health) is there.

While building relationships with the new executive administrators at Central Health Care required work, a Restorative Health executive administrators reported that relationships were built relatively quickly as a result of their previous working relationships earlier in the joint venture lifecycle and from the strong growth and success of Restorative Health.

> Restorative Health executive administrator: Interestingly enough, when we went through the original restructuring, (Dr. Bradford) was the Chief Medical Information Officer at Central Health Care and he was over IT systems and so he actually went through the conversation with us and got to know us through that but then moved into the Chief Medical Officer role and then eventually into the CEO role and so he would come out here and just rave about how impressed he was with the place. So that helped me. So we went from feeling like we were this burden to now people at Central Health Care saying, "How can we get the rest of Central Health Care to be more like Restorative Health?"

In summary, relationships were positively strengthened in three key ways over the lifecycle of the joint venture. As individuals learned about each other and worked together, their relationships and trust increased. Also, relationships and trust was strengthened as physicians and administrators reached out to give help and assistance without expectation of reward or

return. Finally, as relationships were renewed with the new executive administrators at Central Health Care, relationships and trust increased.

Relationships Negatively Impact Trust. Despite the evidence that relationships were an informal control that improved and positively impacted trust over the lifecycle of the joint venture, I found contrasting evidence that relationships also negatively impacted trust over the lifecycle of the joint venture. This evidence was found primarily in the Recovery Stages.

Negative relationships emerged between some Central Health Care administrators and physicians and Atlas Group physicians as they worked together, or avoided working together. I illustrate this finding in the following description by a Central Health Care administrator/physician. His staff over focused on a behavioral issue of an Atlas Group physician and he could not get them to acknowledge that one of their own physicians was at fault for the same behavioral issue.

> Central Health Care administrator/physician: There was a problem with a guy that wasn't dictating notes. And dictation is an occasional problem for physicians so they have…you know, some people are very good. They get it all done that day. Some people let it pile up and every two days they try to sit there and do this marathon dictation thing. Some people have just got this mental block and it doesn't…they just don't do it. Or they kind of, in some of these cases, they expected someone else to do it. So one of the Atlas Group docs was just grossly, grossly delinquent on dictation. Holy buckets, that's awful and all of our guys are screaming, that son of a gun, he should lose his job, this and that, you know. Well, hey, guys, you know, we've got one, too. One of our guys is the same way and we're struggling with that and trying to get him to understand and they go well…that's different. You tell me how it's different. Well, they just want to talk about him, the other guy. They don't want to talk about our guy. Well, we're talking about exactly the same problem, the same behavioral issue. But, it's always a big deal when it's somebody else. And that has to do with "us and them," which hasn't gone away.

In addition, further evidence of the negative working relationships and the negative impact on trust can be seen in the "us versus them" mentality formed by some Central Health Care administrators and physicians. According to a Great Plains University physician, during the Recovery stages, some Central Health Care physicians rarely referred patients to Restorative

Health. Instead, some of these physicians chose to perform a medical procedure they were less familiar with rather than referring the patient or asking a physician from another party for help.

> Great Plains University physician: . . . (Central Health Care physicians) very rarely referred (patients) to (Restorative Health). (Central Health Care physicians) very rarely referred (patients) outside of Central Health Care. (Central Health Care physicians) had disincentives in place not to refer outside (Central Health Care).

> Great Plains University physician: There are some doctors (at Central Health Care) that did two or three special cases a year and that wasn't their area of expertise. They just did them or they would do like one medical procedure that they've never done before. They would just do it because they said well I could do it and they just never seem to have any level of understanding that that may not be the way to do it. If somebody else in town has done 20 of them, why shouldn't they do one? And maybe there is a little bit of expertise that you get. That philosophy never permeated Central Health Care. I think it has now. And I think that they are recognizing, and we're very helpful.

As executives, administrators and physicians reflected on the past five years of the joint venture and looked to the future, several described the importance of relationships as an informal control in different ways. One executive felt concerned that the physicians may not truly forgive each other of the mistakes and weakness in the past and consider the damaged relationships too deep to overcome.

> Great Plains University executive administrator: (Physicians) don't forget that stuff easily. It goes deep and their memories are long and I don't know whether it can be salvaged, those relationships.

In addition, the importance of relationships and trust with specific individuals over relationships and trust with general parties was stressed by an Atlas Group physician.

> Atlas Group physician: …trust is built in person to person relationships. It's not…I can distrust the big gorilla but I don't distrust the doctors (working at Restorative Health). I don't distrust some of the people in the system.

Finally, one executive administrator captured the importance that relationships play in the health care industry and the need to make changes if relationships are not right.

> Central Health Care executive administrator: Yeah, it's really a relationship business and it's … individuals, because this is such a big and complex joint venture, that you have to

> . . . trust certain people both in terms of their knowledge, their ability, their commitment, their follow through and if you don't have that, then you either have to get somebody else involved or try something else, I guess.

Buy-in/Support

While leaders of the three parties ultimately made the decision on behalf of their organizations to join Restorative Health, the leaders also recognized the importance of gaining buy-in from all individuals to support this decision and new organization. According to a Central Health Care executive administrator, the leaders wanted people to buy-in and help mold the joint venture concept so that the partnership could work together like a marriage.

> Central Health Care executive administrator: But the important thing was to get a buy in into the concept and to mold the concept into something we could all believe in. . . . I think you had to have a level of trust going in that everybody was who they said they were, that the concept was a good one and would work and that everybody was committed to it, that you could work together and that it's like a marriage, when you get that in depth to it and your courtship is doing the financials and doing the negotiations on how it's going to be run and what we're going to do, what we're going to focus on, what priorities are going to be there, who's going to take the lead in which areas and all that stuff.

To this end, data from the interviews support the *Managing Transitions* change model developed by William Bridges (2003). According to Bridges's (2003) change is external, situational, event driven, and happens quickly. Conversely, a transition is psychological and involves change on a personal and internal level. The emotional reaction by administrators and physicians to buy-in and support or resist the decision and strategies made by their leaders emerged as an important informal control. This informal control was surprisingly used both a positive/favorable and negative/unfavorable force for and against Restorative Health administrators the vision and mission.

Early in the Negotiation and Implementation stages, a Central Health Care administrator/physician gave the following quote to describe his position on the decision to support or oppose the joint venture and to describe categories of people's level of support.

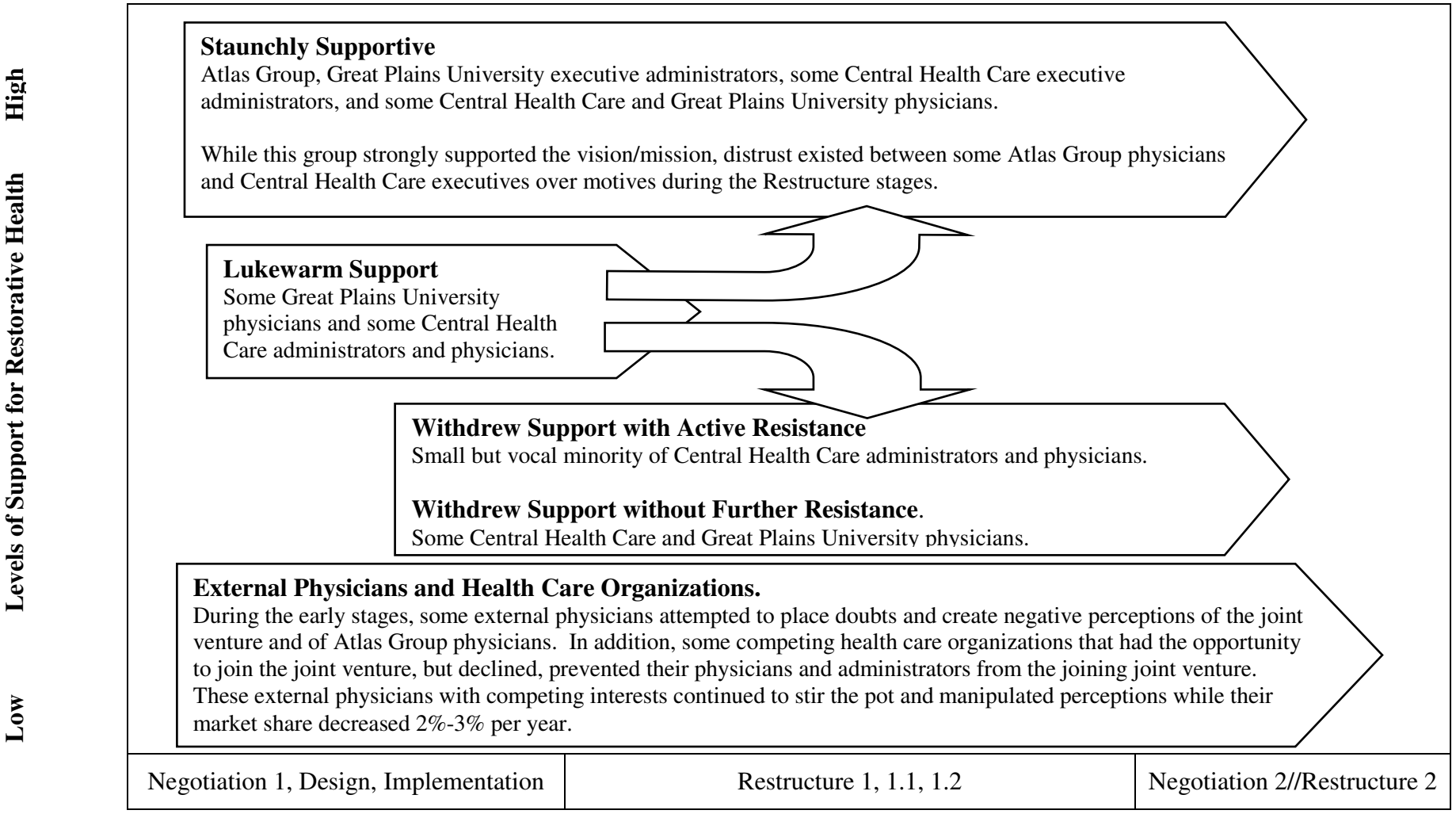
> Central Health Care administrator/physician: . . . I had my doubts, primarily because of things about other people and I'm like, "Do we really want to get involved with this group of people? I've just heard that this is not the greatest thing to do". . . . And the overall proposal, proposed situation to me seemed like yeah, maybe this would work out. So, I guess while there were those that were either staunchly supportive or non supportive of doing this, I was actually lukewarm.

Based on the level of buy-in/support, I grouped people into five levels of buy-in/support: staunchly supportive, lukewarm support, withdrew support with ongoing active resistance, withdrew support with no further resistance, and external people and organizations in direct competition. Table 14 provides a summary of these five categories and their impact on trust. Table 15 provides a timeline how the levels of support changed over the lifecycle of the joint venture.

Table 14
Level of Buy-in/Support and Impact on Trust

Level of Buy-in/Support	Impact on Trust	Description of Trust
Staunchly Supportive	Positive	Initially, trust was strong among the founders, which consisted of physicians in the Atlas Group and mainly individuals at administrative and upper levels of the other two organizations. Upon the launch of the joint venture, some physicians from Central Health Care and Great Plains University immediately brought their practice to Restorative Health. Physicians in this level of support described trust levels as "incredible" and the considered each other their "partners and friends" as they worked, suffered, and overcame barriers together.
Lukewarm Support	Positive and negative	Before and after the launch of the joint venture, support by some administrators and physicians was lukewarm. After the financial crisis and restructure, a divide emerged in the levels of support between Central Health Care physicians who did and did not support Restorative Health. Central Health Care physicians who did not support Restorative Health did not understand why Restorative Health did not adopt the Central Health Care culture and felt neglected as Restorative Health appeared to get an unbalanced amount of resources and attention from Central Health Care executive administrators.
Withdrew Support without Further Resistance	Negative	After the launch, three physicians with high volume practices left Restorative Health and moved out of the area for personal reasons. In addition, two Great Plains University physicians chose to not move their practices to Restorative Health, and a Central Health Care physician with a highly desirable specialty would not be persuaded to join Restorative Health.
Withdrew Support with Active Resistance	Negative	Some Central Health Care administrators and physicians chose not to join Restorative Health. This small, but vocal minority actively worked to oppose their organization's continued involvement in the joint venture because they felt that their organization had been "duped" into joining Restorative Health, perceived that Restorative Health was in direct competition for the same patient population, and felt that Restorative Health diverted financial resources that were needed for their department and other departments within Central Health Care.
External Physicians and Health Care Organizations in Direct Competition	Negative	During the Negotiation and Design stages, former business partners of Atlas Group spread negative information with some Central Health Care physicians to create doubts about working with Atlas Group. In addition, two competing health care organizations who had originally considered joining Restorative Health, but declined, gave leadership positions with significant financial reward to some doctors to retain their loyalty and prevent them from joining Restorative Health.

Table 15
Levels of Support Over Restorative Health Lifecycle



Staunchly Supportive. Over the lifecycle of the joint venture, a core group of people showed staunch support for Restorative Health. Starting with the early stages of Business Concept, Negotiation, and Design, this group mainly consisted of physicians from the Atlas Group, some Central Health Care executive administrators, Great Plains University executive administrators, and Restorative Health executive administrators. According to physicians and administrators, trust among this group was strong and remained strong throughout the lifecycle of the joint venture.

> Great Plains University executive administrator: . . . from my view, I thought (trust among administrators) stayed the same (as things unfolded). . . I thought it stayed the strong.
>
> Atlas Group physician: (the level of trust among the physicians in the Atlas Group) has been unwavering.
>
> Great Plains University executive administrator: I thought that (trust among administrators) stayed strong (throughout the joint venture). I mean I never had, you know, any real bad interactions with the CFO and COO of Central Health Care at the time. I think they saw the University as a very willing partner, willing to restructure. You know, but we're more sophisticated here about the business side of healthcare, and I think for that reason I think they liked working with us.
>
> Great Plains University executive administrator: . . . there was a lot of trust between the administrative folks at Central Health Care and Great Plains University . . . because we were both talking the same language.

As the joint venture opened for business, a few physicians from Great Plains University and Central Health Care showed quick and strong buy-in and support as they immediately moved their entire practice to Restorative Health. According to a Central Health Care physician who moved his practice to Restorative Health and an Atlas Group physician, physicians from Great Plains University and Central Health Care physicians who moved their practices earned "high trust" and became viewed as "partners and friends."

> Central Health Care physician: . . . for the rest of us that work here at Restorative Health, there's been a high level of trust between Ms. Matthews and the rest of us. Once again

> there was distrust of Ms. Matthews by Central Health Care, the rest of the Central Health Care department because of . . . resentment, anger that we'd gone ahead with this venture that (Central Health Care) didn't want to get involved with, this idea that Restorative Health's getting the majority of the resources. But as far as the trust between Ms. Matthews and the rest of the organization, it's been very good.
>
> Atlas Group physician: I think that the uniqueness of what we've done here is that all of us were willing to continue to slog ahead and I have incredible trust…you talk about trust…how do you know…in my partners. We've been to the mat together. We've suffered financially from this. We've seen the ups and downs of this. We've devoted countless hours outside of our normal practice hours and taken countless hours away from our families to push this concept forward and have this happen and we have our disagreements amongst partners and sometimes don't always agree with what Dr. Scott wants to do or what someone else wants to do but I'll tell you, we've been through so much together that I couldn't find a better group of partners to be associated with. Those are my partners and friends and I can't say that there's any distrust in any one of those people.
>
> Atlas Group physician: I have people who work at Restorative Health here from Central Health Care on a physician-to-physician basis who I consider my friends and partners here at Restorative Health who I have ultimate trust in their motives and ultimate trust in what...in their…they've been incredibly supportive of Restorative Health so it's not across the board. There are physicians here who Day One loved working here and they are as supportive and contributive if not more than I am in terms of volumes of cases.
>
> Atlas Group physician: There are three docs from Great Plains University who, on a doctor…four counting Dr. White…on a doctor-to-doctor basis…no problems with trust, no problems with confidence in their…the people who have been there who have been slogging it out with me in the trenches are my partners and friends and I have ultimate trust in them. It's the…there's the disconnect between them and the administrative side of this and the motives of the administrative side.

These accounts tell of the trust that grew between Atlas Group physicians that the Central Health Care physicians who moved their practices to Restorative Health. However, according to a Central Health Care physician, this show of buy-in and support had some unintended consequences. At first, Central Health Care physicians who did not support Restorative Health viewed the conflict as between Central Health Care and Atlas Group. Later, their view changed as they came to view the conflict between Central Health Care and Restorative Health.

> Central Health Care physician who moved entire practice to Restorative Health: And it initially evolved from us against them, us being Central Health Care vs. the Atlas Group.

> Now it is the rest of Central Health Care's department vs. Restorative Health, so I'm considered part of Restorative Health. Not that there's any personal animosity, but I think it really has . . . the battle lines have been drawn in terms of who's . . . if you wanted to say who's side are you on, at least that's been my perspective.

While trust was created and remained relatively high throughout the joint venture among the founders, executive administrators, and some physicians from Great Plains University and Central Health Care, buy-in/support for Restorative Health was not as high or consistent as a whole for executive administrators, department administrators, and physicians within Central Health Care. According to a Restorative Health executive administrator and Central Health Care administrator/physicians, a split in the level of buy-in/support developed. As a result, while the high level of buy-in/support at the founders and administrative level positively impacted trust, the lack of buy-in/support by some physicians negatively impacted trust.

> Restorative Health executive administrator: The trust (with Central Health Care) was at the administrator level, not with the individual physician level. I assumed that the Central Health Care administration was building the trust with their physicians and that was not the case.

> Central Health Care administrator/physician: . . . trust remains pretty much as it was. The trust remains on the upper levels of the people who can see the big picture and the distrust has been tempered, at best, but(distrust has) never really been broken down and gone away.

> Atlas Group physician: And I think we all thought that Central Health Care administration, Central Health Care department could work as a unit and would see the benefit out of this. If Restorative Health succeeds, Central Health Care as a whole system succeeds. But (the Central Health Care system) doesn't individually benefit their physicians to be (at Restorative Health) other than a great place to work and so some of their docs have bought in to the concept. They're terrific partners here. The guys that are here have been committed just as I have been committed to Restorative Health in terms of on a doc level but there's a whole half or more of their physicians who have elected and chosen not to come here and do their business here. And so they are partners because of Central Health Care, but they're not my partners in this venture.

Lukewarm Support. While physicians from the Atlas Group and some physicians from Great Plains University and Central Health Care showed buy-in and support for Restorative

Health by quickly moving their medical practices to Restorative Health, other physicians sat on the fence and were reluctant to follow. According to a Central Health Care administrator/physician, a decision to support Restorative Health was all or nothing.

> Central Health Care administrator/physician: . . . if anybody asked me what I thought, I sort of told them well, I don't know, it might work or there might be some problems too but, I don't know, in retrospect, it was a . . . made a big thing to jump off into . . . it wasn't a small proposal. It was . . . it ended up being a big monstrosity sort of thing. It wasn't like you could just wade in. We made that decision and you were in, baby.

In addition, for some people at Central Health Care, the overall lukewarm response to buy-in and support the joint venture was a combination of people who either supported or opposed the partnership.

> Central Health Care administrator/physician: . . . (the decision to move our practice from Central Health Care to Restorative Health) was a significant practice change . . . I . . . have not been able to get other people to do. So, I try to lead by example by doing that and it didn't rub off a whole lot.

> Central Health Care physician: I was involved with our department and bringing them on board and when you talk about trust, there wasn't a lot of enthusiasm from our department. Several people were on board, but there were several that were against this venture from the outset. And that, I would say, has probably been our biggest challenge that we've had in going forward and making this a success. So the major partner had people in the department including other physicians who didn't want to get on board with this and to me that was the biggest stumbling block that we had early and continue to have today.

According to a Restorative Health executive administrator, even an executive administrator at Central Health Care vacillated in his level of support for Restorative Health.

> Restorative Health executive administrator: . . . (the Central Health Care executive) was very inconsistent (in his level of support) and so one day he'd be pro-Restorative Health and the next day he'd be like anti-Restorative Health and we'd never really know like in which room, which meeting we were going to hear we've got all this debt here and we, you know, and then how's Central Health Care going to deal with that and we can just take Restorative Health over, and all that kind of thing. He would be like that extreme and then other days he would think we're the great thing since sliced bread . . .

While leaders of the three parties believed their physicians would move their practices over in a timely manner as agreed upon, this was not the case. Instead, a division emerged among physicians where some moved their practice and some did not move their practice. According to an Atlas Group physician, this unexpected division in buy-in/support by Central Health Care physicians created a complicated situation for Central Health Care executive administrators.

> Atlas Group physician: . . . I think (Central Health Care executive administrators) have to try to do something different because (Restorative Health) is such a hornet's nest for them and for the physicians that come (to Restorative Health). There's some that want to be part of this, there's some that don't.
>
> Restorative Health executive administrator: So (trust) became an issue early on when there were several key leaders in the Central Health Care department that just basically said "I'm not working (at Restorative Health). I don't even like these guys."

According to the interview data, Central Health Care physicians who were reluctant to move their practice felt resentment towards Central Health Care and Restorative Health executive administrators. This resentment stemmed from two perceptions. First, some believed that Central Health Care gave too much attention and resources to Restorative Health and neglected their needs as a department within Central Health Care.

> Central Health Care administrator/physician: All of my bitterness and cynicism comes from the fact that I'm at Central Health Care and I feel neglected.
>
> Central Health Care physician: It's been an issue for the rest of our department too because the feeling is that Restorative Health gets all the resources, the advertising, the top billing, and that Central Health Care department has been considered a second class citizen.

Second, some Central Health Care administrators and physicians were surprised that their organization was expected to change some of their practices to conform to Restorative Health when Central Health Care was responsible for rescuing and keeping Restorative Health alive. Instead, these physicians expected Restorative Health to adopt the Central Health Care culture.

> Restorative Health executive administrator: So (people frequently ask me) why is it that (Restorative Health) demand so much attention or why is it that (Central Health Care) has to change everything for you, why aren't you like the rest of Central Health Care?

Thus, while some physicians from Central Health Care and Great Plains University were staunchly supportive, others were more lukewarm, cool and stand-offish in their level of buy-in and support towards Restorative Health.

As described earlier, an outward demonstration of physicians' buy-in and support or opposition to the joint venture was manifest at different times during the joint venture lifecycle. For those physicians who withdrew their support of the joint venture, they tended to distance themselves from Restorative Health and either ceased to oppose the joint venture or continued to actively oppose the joint venture. The section below explores the actions of physicians in these two categories.

Withdrew Support without Further Resistance. After withdrawing their support for the joint venture, some physicians from Great Plains University and Central Health Care chose not to have any further contact or involvement with the Restorative Health. This decision is illustrated in the example below of two physicians from Great Plains University.

> Central Health Care administrator/physician: . . . in principle it was an understanding (to move your medical practice), but no one had ever gotten those two (Great Plains University physicians) to sign on the dotted line. They were at the table. They participated in the discussions, but little did we know . . . little did I know that they were like some of my partners, they were resistant to the idea. . . they didn't like the idea and, you know what, I'm just going to keep doing my job, you know. And even though they were, at least one of them was on the Board, they said no, I'm just going to keep my practice down here and they did not come out and participate.

In another example, a Central Health Care administrator tried unsuccessfully for several years to persuade a physician in his department with a highly desirable specialty to join Restorative Health.

> Central Health Care administrator/physician: . . . one of my partners has a medical specialty in high demand and we heavily recruited him to come (to Restorative Health), but he has not. For five years he has resisted. He just didn't want to become involved here. So that was, for me, very difficult as (department administrator). And then later I've been on the Restorative Health board for ever since we opened, whenever we had a Board and that's always been something that's been an issue for me. It's been an issue for the rest of our department too because the feeling is that Restorative Health gets all the resources, the advertising, the top billing, and that Central Health Care department has been considered a second class citizen.

While a failure to persuade some physicians to join Restorative Health generally tended to have a negative impact on the joint venture, some positive impacts were achieved when some individuals who opposed the joint venture left the organization.

> Restorative Health executive administrator: . . . there were some individuals at Central Health Care that were very caustic and . . . they're not there anymore.

Withdrew Support with Active Resistance. While dealing with physicians who withdrew their support, but discontinued any further contact or resistance to the joint venture, posed some challenges, dealing with administrators and physicians at Central Health Care who withdrew their support and continued to actively resist the joint venture proved to be a bigger challenge for leaders of Restorative Health. According to administrators from both Central Health Care and Restorative Health, while the number of people who continued to actively resist the joint venture was small, they were very vocal about their resistance.

> Central Health Care administrator/physician: . . . there were a number of people in the Central Health Care department who were very much against this partnership.
>
> Restorative Health executive administrator: But regardless of what I would say and what the outcomes were, there still were this vocal minority (within Central Health Care) that remained unhappy with the whole Restorative Health decision.
>
> Restorative Health executive administrator: (Some Central Health Care administrators and physicians) refused to work (at Restorative Health) and sat outside and were critical of their organization's decision making, etc.
>
> Restorative Health executive administrator: . . . we got the impression that people didn't like each other and didn't want the project to succeed.

According to physicians and administrators from all three parties, trust between this group of people within Central Health Care and anyone involved with Restorative Health was very low because they were angry with their own organization supported Restorative Health and because they believed that Restorative Health's financial benefits unfairly benefited the Atlas Group.

> Atlas Group physician: . . . I'm just going to guess at this particular point you'll find no trust there. None. Between the (Central Health Care) physicians and their own administration because they felt wronged in this from the start.

> Restorative Health executive administrator: Because (some Central Health Care physicians) felt that their organization had been duped into supporting Restorative Health and that Restorative Health was really supporting the financial interests of the Atlas Group docs, in particular. This was a minority but highly vocal viewpoint.

> Central Health Care administrator/physician: Dr. Jones is a guy (at Central Health Care) who had serious reservations of this and was the, has struggled mightily with it. He's our current department chair. Dr. Jones was violently opposed to the Restorative Health concept from the beginning and remains so.

Besides the negative feelings of inequity and resentment described above by some Central Health Care administrators and physicians, one core and burning issue seemed to fuel the continued resistance against Restorative Health. This issue was a perception of internal competition between Restorative Health and administrators and physicians from Central Health Care who chose not to participate in the joint venture. According to a Central Health Care physician, telling the story of this issue and its impact is the real story that needs to be told.

> Central Health Care physician: . . . from my way of thinking with regard to trust, that's where the real story is (how Central Health Care people who do not support Restorative Health have affected and influenced the success of Restorative Health even though they were not directly involved in Restorative Health).

> Central Health Care physician: . . . it's not so much trust among people that work (at Restorative Health), it's trust among those that still have some . . have an interest here in terms of it being part of our Central Health Care department and even though they're not working here directly.

> Central Health Care physician: So the major partner had people in the department including other physicians who didn't want to get on board with this and to me that was the biggest stumbling block that we had early and continue to have today.

This issue of internal competition within the joint venture will be explored further in the next section of this chapter.

External physicians and health care organizations. While Restorative Health experienced resistance and opposition from administrators and physicians within their three parties, they also experienced resistance from external physicians and organizations in direct competition with Restorative Health. One source of external resistance came from physicians who used to be business partners with Atlas Group. According a Central Health Care administrator/physician, these external physicians contacted Central Health Care physicians who were lukewarm or opposed to the joint venture and planted doubts about working with Atlas Group physicians and gave reasons why Central Health Care should withdraw their support from Restorative Health.

> Central Health Care administrator/physician: There was an independent doc who was a big player in town who I had a conversation with one night and as we were talking about this he said there's no way I'll ever do a case (at Restorative Health) if it's going to put dollars in Dr. X's pocket.

> Central Health Care administrator/physician: (Some Atlas Group physicians) had a reputation of being difficult people to work with for a variety of reasons. . . some of my partners are friends with some of (Atlas Group's) former partners and started hearing all these stories, so and so's bad because of this and that and people like to talk. So there was that. So again the naysayers (within Central Health Care) were being armed with more material.

> Restorative Health executive administrator: . . (some Central Health Care administrators and physicians are receiving) third-hand information about how (Atlas Group physicians) can't be trusted, they don't do their work right, they don't do their charts, they're not trustworthy partners. We got rid of them a long time ago and (some Central Health Care administrators and physicians) are not smart enough to sit down and think about what the motivation is for those external doctors to be feeding them this stuff.

> Restorative Health executive administrator: So, (Central Health Care physicians) can't say that things weren't transparent. They do say they don't trust…they don't believe (the

> compensation information I share with them). Again, fueled by the outside party that's getting their market share whacked by 2%-3% every year as patients…this place grows and theirs diminishes. Again, no ability (for Central Health Care physicians) to put context around the words they're hearing.
>
> Restorative Health executive administrator: Interestingly enough, a lot of their interpretation of the way Atlas Group does business, etc. is fed to them by outside doctors who are personal friends of the Central Health Care physicians that have a competing interest in this new project and they can't see through the fact that by those outside doctors stirring the pot, that they're being duped. They have no recognition that they're being manipulated.

In addition, resistance came from competing health care organizations. These competing organizations had initially been invited to be a partner in the joint venture, but declined. Now, these health care organizations saw Restorative Health as a threat and aggressively engaged their doctors in leadership positions as a strategy to keep the doctors within their organization and prevent them from joining Restorative Health.

> Restorative Health executive administrator: Nationwide Health Care owns the Great Plains University hospital. Nationwide Health Care acts like they own a lot more than that and they push their weight around in certain areas. While they don't own the academic health center which is the teachers and the programs and what not, they try to act like they do. They push their doctors around like they do and they control their doctors some and they've controlled some of their guys by these sort of interesting kind of, well, let's have a new committee and we'll pay you to be the chairman of the committee as long as you keep…sort of the implication is you'll stay here, won't you.
>
> Atlas Group physician: You know, it's been very interesting and I think that Dr. White really underestimated what the University could bring and so that was early on one of the problems. The University has been able to bring more as time as gone on because they've brought new people, they've hired new people and as they come here they like working here and so several of the guys have come here and so the University's numbers have come up but they just couldn't bring it out of the chute because Nationwide Health Care really clamped down and there was lots of threats back and forth, apparently.
>
> Atlas Group physician: Part of the difficulty opening the doors here and one of the things you should specifically talk to Dr. White about was the relative surprise that happened to him by the outside influence in the community in that he was more convinced that it would be easier to bring business from the University that the University physicians would be able to transfer there and would be more interested in transferring their practices here but what they ran into and the obstacle that blindsided them was the

> reaction in the community from Nationwide Health Care. . . . Nationwide Health Care . . . actually bought off the physicians.

As can be expected in any business related venture, people and organizations will attempt to oppose and resist new entrants into the market place that threaten their market share (Porter, 2008). As described above, external physicians planted doubts and competing health care organizations prevented physicians and administrators from joining Restorative Health. From an internal perspective, buy-in and support among administrators and physicians for the joint venture emerged as a powerful informal control that created a positive and negative impact on trust. While buy-in and support was created and remained strong at the founder and upper-levels of the joint venture, buy-in and support between Great Plains University and Central Health Care physicians was split. Physicians who withdrew their support tended to either discontinue any further resistance after withdrawing or continue active resistance to the joint venture. Those within Central Health Care who continued to resist the joint venture did so because they perceived that Restorative Health received an unfair amount of attention and resources and that the joint venture was in direct competition with their internal department. This issue will be addressed in more detail in the next section.

Conclusion

Based on the interviews, informal controls emerged as an important mechanism leaders used to shape attitudes and behaviors. The vision and mission of Restorative Health was formed early in the joint venture and proved to be a compelling and consistent force in building trust and helping parties endure the difficult stages of the joint venture. Relationships were an informal control that created both a positive and negative impact on trust for different physicians and administrators.

Finally, buy-in/support from administrators and physicians for the joint venture was an informal control that had both a positive and negative impact on trust. Some people bought into and supported the goals of the joint venture while other people withdrew and even actively opposed their organization's involvement in the joint venture.

Chapter Seven

RESULTS – EVOLUTION OF TRUST OVER LIFECYCLE

In Chapters 5 and 6, I described results for Research Questions 1 and 2 to understand how formal and informal controls at the Restorative Health joint venture shaped and influenced attitudes and behavior. In addition, these chapters documented how changes to these specific controls impacted trust. To answer Research Question 3 and to gain insights into how leaders experience trust during each stage of the joint venture, I asked participants questions and listened for clues to answer the following questions.

a. How did changes to formal controls impact the development of trust between firms in the joint venture?
b. How did changes to informal controls impact the development of trust between firms in the joint venture?

In Table 16 below, I describe the code families and sub-code families according to the lifecycle stage of the joint venture where changes in formal and informal controls impacted the development of trust, as reported during my interviews.

Table 16
Family and Sub-family Codes for Changes in Trust

Code Family	**Code Sub-family**	**Quotes within Sub-Family**
Design	Decrease in Trust	11
	Increase in Trust	6
Negotiation	Decrease in Trust	1
	Increase in Trust	5
Implementation	Decrease in Trust	5
	Increase in Trust	0
Restructure 1	Decrease in Trust	17
	Increase in Trust	5
Restructure 1.1	Decrease in Trust	4
	Increase in Trust	5
Restructure 1.2	Decrease in Trust	4
	Increase in Trust	5
Restructure 2	Decrease in Trust	1
	Increase in Trust	15

Based on these family and sub-family codes, I determined that leaders experienced both trust and distrust over the lifecycle of the joint venture, and I will describe the results of these research questions in Chapter 7.

How Leaders Experienced Trust

In this case study, I already wrote and reported on the high trust experienced throughout the joint venture by physicians and administrators who were *staunchly supportive* of the joint venture. This group formed a close bond of trust from the beginning as they formed the business

concept, designed and implemented the joint venture. After the Implementation stage, trust continued to evolve among this group as some physicians from Central Health Care and Great Plains University moved their practices to Restorative Health. As cited earlier in this chapter, trust levels among these physicians was often described as "incredible" and physicians were considered "true friends and partners" because they "sacrificed," "suffered together" through the challenging times and now celebrate the success of the joint venture they created.

As the parties worked through the challenges and changes from the restructuring, trust between Great Plains University and Atlas Group remained strong. However, during this time, the University played a more neutral role as conflict and distrust emerged between Atlas Group and Central Health Care administrators and physicians who did not support Restorative Health.

> Great Plains University executive administrator: At the physician level, trust was really strong between our physicians at Great Plains University and Atlas Group. I think of Great Plains University as like Switzerland, we're more neutral . . .

How Leaders Experienced Distrust

According to a Central Health Care administrator/physician, trust and distrust emerged and existed on two levels.

> Central Health Care administrator/physician: Trust existed on one level and substantial distrust existed on another level. The trust existed on the higher levels of the, shall we say "visionaries." The people who saw what this could be and we trusted each other to participate and to cooperate and to be good citizens and to kind of watch out for each other and help each other along. To see that, this was a success for everyone. And that was what some of us saw. That's what I saw. The truth of the matter is that really each organization had distinctly different goals and in what they wanted out of Restorative Health and saw potentially the others as an end to their own means and so as we moved along and we ran into problems, it started to become every man for himself. . .

After the financial crisis and Restructure 1, conflict developed and high distrust evolved between some Atlas Group physicians and Central Health Care physicians who withdrew support and continued to actively oppose Restorative Health.

> Dr. White: Yes, so trust has been strong between Atlas Group and Ms. Matthews and I (Restorative Health executive administrators). Trust has been strong between Central Health Care leadership and Ms. Matthews and I. Trust has always been strong between Great Plains University and both parties but trust has been sorely lacking between Atlas Group and Central Health Care.
>
> Atlas Group physician: . . . so the business flipped upside down from what it was supposed to be so I think there was trust initially. There's been no change in the trust that I have for my partners. There's been an increase in trust in the doctors from Great Plains University. There's been a substantial increase in trust in the physicians from Central Health Care that are working (at Restorative Health). The trust in the administration and really the administration at Central Health Care is my partner even though the docs here are an outcropping of that and that trust took a humongous hit six months into this.

To a high degree, the feelings of distrust evolved between Atlas Group and Central Health Care because they both formed and held negative perceptions of each other. These perceptions are summarized in Table 17 and described in further detail in the section below.

Table 17
Levels of Support over Restorative Health Lifecycle

Atlas Group's Negative Perceptions of Central Health Care	**Negative Perceptions by Central Health Care Administrators and Physicians Who Withdrew Support and Actively Resisted Restorative Health**
• Some Central Health Care physicians did not move their practices to Restorative Health, as promised. • Central Health Care executive administrators only care about getting positive cash flow from Restorative Health. • Central Health Care executive administrators were too "heavy handed" and "forced" us to restructure. We lost our financial investment and our power, and we were left with no other options except to accept Central Health Care's offer. • Some Central Health Care administrators and physicians don't care what happens to Restorative Health. They withhold their support in hopes that Restorative Health will fail and close.	• Atlas Group physicians are excellent physicians, but money grubbing. • Some of our own general practice physicians refer their patients to Restorative Health without the realization that Central Health Care already has an internal department to care for these patients. Thus, because our organization supports both groups, we are competing against ourselves for many of the same patients. • While our own executive administrators provide large financial resources to keep Restorative Health in business, our own internal department suffers financially. We lose revenue as patients go to Restorative Health and yet we are left with the same internal cost structures.

According to a Restorative Health executive administrator, trust was low between both groups because neither was willing to invest much effort and look beyond the negative perceptions or try to understand the other group's perspective.

> Restorative Health executive administrator: You have to understand there are three different perspectives on things and everything's a compromise. You've got to reach a middle ground. Now I just wish that Central Health Care would put effort into understanding the perspective of the Atlas Group docs and vice versa. There's way too little of that because there's no trust. You know, from the Central Health Care perspective, the Atlas Group guys are just money grubbing…excellent physicians, but money grubbing, only interested in money this and that and this is not true, completely not true and from the Atlas Group docs perspective, all Central Health Care thinks about is the fact that they get positive cash flow out of this clinic and continue to benefit when they don't, and that's not true. So, there's too little time those two parties trying to understand the other perspective, like zero and either…both parties are just as guilty. It's like dealing with small children, really. In order for the thing to work smoothly without

> all this conflict, people have to spend time understanding the other perspective and that just has not happened.

In addition, some Atlas Group physicians distrusted some administrators and physicians at Central Health Care because they did not deliver on their commitment to move their medical practices to Restorative Health as originally promised and felt forced to accept the restructure agreement.

> Restorative Health executive administrator: Atlas Group thought that when Central Health Care agreed to build the Restorative Health facility that they would deliver on promise to move their medical practices. (Atlas Group) didn't not understand that Central Health Care administration cannot order their doctors around and make them do stuff they don't want to do. (Atlas Group) thought that because the physicians were employed by Central Health Care that Central Health Care administration would, if need be, take a heavy hand and tell them you're going there or you're gone and that didn't happen. So that's where it started and then with the reorganization the Atlas Group docs felt that they were forced into an arrangement with a gun at their heads. They had personal financial investment and they would have lost everything had they walked away from it and so they felt that they had no power and Central Health Care took advantage of that. So that's where it started.

This deep distrust evolved between Atlas Group and Central Health Care and Central Health Care and Restorative Health in part from a perceived dichotomy by some Central Health Care administrators and physicians and some Atlas Group physicians. Some Central Health Care administrators and physicians perceived their organization's efforts to support Restorative Health and keep it alive had a negative and opposite impact on their own internal medical department. As a result, a perception grew that Central Health Care and Restorative Health were in direct competition with each other and that a positive financial recovery by Restorative Health could only result in a negative financial loss for Central Health Care or vice versa. According to some Central Health Care administrators and physicians, this dichotomy and feeling that the two groups were hurting each other and acting as roadblocks to the other's success created deep distrust.

> Central Health Care administrator/physician: . . . (Some Central Health Care physicians are) saying we don't really want to (join Restorative Health), and Atlas Group physicians are screaming you're not getting on board with the whole thing and you are hurting us and we're saying yeah, we're hurting you, yeah, but you know what, I don't really care about you and meanwhile our organization is pumping millions and millions of dollars into keeping this thing afloat and our guys are going let it die. . . pull the plug.

> Central Health Care physician: Restorative Health opened and took (Central Health Care) business away from here and suddenly we're left with the same cost structure, minus maybe a couple of employees, but the same facility structure and all the other stuff and all of a sudden our revenue has gone down and our cost structure stays up. All of a sudden our profitability goes away. So what was a profitable department that we were in with a share in its margin . . . we don't get that anymore.

In addition, an Atlas Group physician explained how this distrust was compounded by a perception by some Atlas Group physicians that Central Health Care forced them to accept the restructuring offer after the financial crisis.

> Atlas Group physician: . . . it's an immense distrust in my relationship with Central Health Care as to the events that transpired (after the financial crisis) there because the reality is that from our perspective, we had a pro forma about the performance of this building and how it was going to work which was dependent on volumes of surgeries and business profit and the three groups all committed to "X" amount of business and Central Health Care has had doctors come here who are terrific doctors who work here solely but Central Health Care's been unable, if you will, to get all their doctors to buy into the concept. And so the numbers that they said they would bring to generate, to support the success of Restorative Health have never lived up to what they were. Now, our numbers aren't, whoever put the pro forma together was overly, overly optimistic about the workings of the place. But it…there was a lot of distrust at that time when we almost went belly-up as to the motives of the partners.

While these events caused some Atlas Group physicians to distrust Central Health Care, an equal amount of distrust was felt by Central Health Care administrators and physicians with lukewarm support and those who actively resisted Restorative Health. According to a Central Health Care administrator/physician, some people at Central Health Care understood their organization's strategy to help Restorative Health become profitable. However, reaching this "laudable goal" seemed to be at the expense of their own internal department.

> Central Health Care administrator/physician: Well, the idea of if we can get Restorative Health up and back on its feet, it's a good thing for everyone and that is something that, again, the high up type of people see as a laudable goal. The question is at what cost is that going to happen? And the place that has suffered the most is actually the Central Health Care department because the people who have the best opportunity to remedy the situation are the ones that stand to lose on the other side, by remedying the situation. . . Whatever our department would do to support Restorative Health was actually a detriment to some of the other things. . . changing behaviors would benefit Restorative Health the most were also the ones that would lose.

Over time, Central Health Care's continued support helped Restorative Health to become financially stable and several new programs at Restorative Health became very successful. However, according to a Central Health Care administrator/physician, Restorative Health's success continued to contribute to feelings of distrust as a perception of internal competition emerged and as some of Central Health Care's own general practice physicians referred patients to Restorative Health without considering sending the patients internally to Central Health Care's department.

> Central Health Care administrator/physician: The Urgent Care Clinic at Restorative Health right now, which is one of (Restorative Health's) shining successes, is directly taking business from the practice (at Central Health Care) because our urgent care people and a lot of the primary care people, when they have a health care need, don't even think about sending their patients anymore (to Central Health Care).

> Central Health Care administrator/physician: . . . Dr. Brown's father or father-in-law, one or the other, was a shrewd business person in (Midwest city), I guess, and as soon as we were in this and he was talking to him about it, he's like,. . . you guys at (Central Health Care) are idiots. And he said, what do you mean, what do you mean? Because (Central Health Care physician) actually has been a fairly big supporter of (Restorative Health), at least initially. You've just violated the first rule of business. You guys are competing with yourselves. What are you doing?

While the two groups had some understanding and appreciation for the other party's dilemma, they both distrusted each other because they perceived that the other party was responsible for their separate financial losses.

> Central Health Care administrator/physician: I remember (Atlas Group physician) saying to me, I've poured my heart and soul into this thing for the last five years, which he had,

> and all of a sudden, poof, it could be gone and he's depending on (Central Health Care) to do something Central Health Care don't want to do, which is actually detrimental to us to support him.
>
> Atlas Group physician: . . . the problem is that Central Health Care owns 2/3 of this business, excuse me, 60% about, and so when they make a dollar in their system at Central Health Care, it's a dollar for the system. When they make a dollar (at Restorative Health), it's 60 cents. So there's a lot of competition, if you will, so anyway you develop a suspicion and wonder about why hasn't Central Health Care committed to this place.

This perception of internal competition and dichotomy that only one side could succeed at the expense of the other side was the core of a lot of the distrust. According to an executive administrator at Restorative Health, trust was most fragile during the first three years after the first restructuring.

> Restorative Health executive administrator: I would say, at that point (Restructure 1), the trust was very, very, very fragile because there wasn't a lot of trust by the Atlas Group about what's Central Health Care intent really was.

While the partners of Restorative Health worked through the restructuring, some members questioned how long trust would take to develop or if trust could even exist among physicians and administrators. According to an Atlas Group physician, he did not see a significant increase in trust over the lifecycle, and he believed trust would take a long time to develop.

> Atlas Group physician: I don't think there was a lot of trust involved and I'm not sure there still is a lot of trust. I mean, I think that takes a long, long time to develop. . . I think that we're a long way away from a culture of trust.
>
> Atlas Group physician: I don't think I would say that there's been some great surge in trust. I think trust is something . . . is a long, long term situation that's affected by lots of things.

In addition, administrators and physicians acknowledged and described the strong personalities and ultra competitive nature of most physicians as a likely reason that these two groups may never develop high trust.

> Restorative Health executive administrator: Doctors are hard people to deal with, in general. Most administrators will tell you that. That's because you can't control them.
>
> Great Plains University executive administrator: . . . you will never find in any organization complete harmony with physicians. By their nature, they are incapable of . . . complete harmony. There's always professional jealousy. They consider themselves all the "A" students in the world, therefore, they're competitive, they're independent . . .
>
> Central Health Care physician: . . . the old joke is the only thing you can get two doctors to agree about is the incompetence of a third. And I think to a large extent it is difficult to get groups of physicians to work together.

Despite the financial and relationship challenges experienced at Restorative Health, the joint venture began to experience some success as members of the *staunchly supportive* group pressed forward and persevered. Restorative Health executive administrators cited several examples how financial success contributed to an increase in trust.

> Restorative Health executive administrator: We had lots of issues to deal with to keep the doors open and the docs felt like we were under the thumb of Central Health Care, (Central Health Care) was making decisions willy-nilly and it was hard for us to have our voice heard and it was, but again it was to keep the thing going so people just kept hanging on and then as it…starting the end of 2007, and then onward the trust just snowballed because of the success of the thing and the success was, in part, because we continued with the policy of open honest communication.
>
> Restorative Health executive administrator: By 2007 and 2008, a new era emerged as people started to pull behind the same wagon and people were more comfortable with transparent decision making. Dr. White and Ms. Matthews had already worked well together. Thus, trust increased.
>
> Central Health Care administrator/physician: . . . when things started to fall apart, within the first several months of opening, the distrust exploded. And, it was a miracle, really, that they were able to pull this thing together.

In addition, the timing of Restorative Health's success helped Restorative Health executive administrators to gain trust and credibility in the eyes of Central Health Care's new executive team. According to a Restorative Health executive administrator, the joint venture was no longer seen as a burden to Central Health Care, but instead a model to be followed and replicated.

> Restorative Health executive administrator: . . . (the new executive of Central Health Care) would come to (Restorative Health) and just rave about how impressed he was with (Restorative Health). So that helped me. So we went from feeling like we were this burden to now people at Central Health Care are saying how can we get the rest of Central Health Care to be more like Restorative Health.
>
> Restorative Health executive administrator: . . . I think (our relationships with Central Health Care) is better because I think they . . . don't hear people at the top talking about Restorative Health as a problem or a financial drag (anymore). . .
>
> Restorative Health executive administrator: So we gained a lot of credibility that way early on and then as the growth started, every single year, we'd have 20-30% growth in the clinic and as we doubled our margins, improved our margins by either usually 100% every single year. So as our growth and financial success came along, we became more and more and more credible (with Central Health Care executives) and so trust levels were there.

Conclusion

This chapter reviewed the process Restorative Health followed to build trust and described how leaders experienced trust during each stage of the joint venture. While trust existed and increased among a group of *staunchly supportive* people at Restorative Health, the majority of this section described the challenges experienced to build trust between Atlas Group physicians and Central Health Care administrators and physicians who withdrew support and actively resisted Restorative Health. This distrust was a result of negative perceptions of the other party.

Atlas Group physicians distrusted some Central Health Care administrators and physicians because they withheld support and did not bring their practice to Restorative Health which contributed to the loss of revenue for Restorative Health and a loss of personal financial investment of the Atlas Group physicians. Conversely, some Central Health Care administrators and physicians distrusted the Atlas Group because they perceived them as "too business minded" and efforts by Central Health Care executive administrators to support and build Restorative

Health created internal competition with and a loss in revenue for Central Health Care's own internal medical department.

During the last two years of Restorative Health, the joint venture experienced solid financial success and growth which helped trust to further develop between administrators and physicians. This trust was necessary as the three groups returned to renegotiate and restructure their joint venture agreement.

Chapter Eight

DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

In Chapter 1, I stated that organizations form joint ventures to manage risk and uncertainty and to gain a competitive advantage over their competition (Das & Teng, 1998). I also reported that many joint ventures fail because these organizations experience a different type of risk and uncertainty as they join together and try to work as a new and combined organization (Das & Teng, 1998). The purpose of this study was to gain insights and understanding into the factors that lead to successful alliances. In particular, I focused on the following research questions.

RQ1: What roles do formal controls play in influencing the establishment of trust during each stage of the lifecycle?

RQ2: What roles do informal controls play in influencing the evolution of trust during each stage of the lifecycle?

RQ3: How do leaders experience trust during each stage of the joint venture lifecycle?

RQ4: What is the process to build trust within the joint venture?

To study and gain insights into this phenomenon, I used a case study methodology and interviewed eleven leaders at a three-party health care joint venture who had first-hand experience working with all stages of a joint venture lifecycle. Using "why" and "how" questions, I asked leaders to describe their experience during the different stages of the joint venture and asked them to describe examples of trust or lack of trust they experienced during each stage. In addition, I asked leaders to describe how they experienced formal and informal controls during the lifecycle and how these controls increased or decreased over the lifecycle.

As I analyzed documents and transcribed interview data, I looked for clues to my research questions and captured relevant quotes from the transcripts and sections from the documents into family and sub-family codes using interpretive research software. After coding the data, I analyzed the code families and quotes within the code families and organized the data into key themes and stages of the lifecycle. I used member checking at two points during my data analysis process, and interview participants validated my themes and lifecycle and shared additional information to help me further refine my analysis.

Based on interviews with executive administrators, department administrators, and physicians across the three parties, results supported existing literature, shed light on new knowledge, and identified areas for future research. In particular, results confirmed the use of financial reward systems, organizational structure, and selection and placement of people as formal controls to shape attitudes and behaviors towards joint venture goals. While these formal controls were adjusted over the lifecycle of the joint venture, organizational structure and the selection and placement of people had an overall positive impact on trust while financial reward systems had an overall negative impact on trust.

In contrast, results confirmed the use of relationships as an informal control and compelling vision/mission and buy-in/support were identified as new forms of informal control. While relationships between individuals changed over the lifecycle and had a positive and negative impact on trust, compelling vision/mission and buy-in/support did not change over the lifecycle. Compelling vision/mission had an overall positive impact on trust and buy-in/support had both a positive and negative impact on trust.

Through these formal and informal controls, trust and distrust evolved among leaders over the lifecycle of the joint venture. Trust evolved among some administrators and physicians

who actively worked together and supported the goals of the joint venture. Among this group, trust levels were high as they sacrificed and suffered together through the challenging times until the joint venture became stable and profitable.

Conversely, distrust evolved at a different level as some administrators and physicians at Central Health Care withdrew their support and actively opposed their organization's involvement in the joint venture. These feelings of distrust were largely driven by negative perceptions that the Atlas Group and Central Health Care formed and held about each other. Towards the end of the Restructure 1.2, the level of distrust between Atlas Group and Central Health Care began to decrease as new executive administrators were hired at Central Health Care, the joint venture experienced growth and financial success, and as the parties anticipated positive changes from Negotiation 2/Restructure 2. While these changes created greater equity in the financial reward systems among the three parties and created organizational distance between Atlas Group and Central Health Care, a level of distrust continued to exist among some groups. Table 18 on the following page provides the summary and timeline of the impacts of formal and informal controls on the evolution of trust over the lifecycle.

Table 18
How Formal and Informal Controls Impacted the Evolution of Trust

	Overall Impact on Trust Over Lifecycle Stages															
	Staunchly Supportive Group								**Central Health Care Group Who Actively Opposed Restorative Health**							
Legend: ▼ = Negative Impact ▽ = Somewhat Negative Impact △ = Somewhat Positive Impact ▲ = Positive Impact Blank = Not Applicable	Form Business Concept	Negotiation 1	Design	Implementation	Restructure 1	Restructure 1.1	Restructure 1.2	Restructure 2 /Negotiation 2	Form Business Concept	Negotiation 1	Design	Implementation	Restructure 1	Restructure 1.1	Restructure 1.2	Restructure 2 /Negotiation 2
Formal Controls																
Financial Reward Systems					▼	▼	▼	△								
Organizational Structure			▲	▲	△▽	△	△	△				▼	▼	▼	▼	
Selection and Placement of People			▲	▲	▲	▲	▲	▲						▼	△	
Informal Controls																
Compelling Vision/Mission	▲	▲	▲	▲	▲	▲	▲	▲				▼	▼	▼	▼	
Relationships	▲	▲	▲	▲	△▽	△	△	▲				▼	▼	▼	△▽	
Buy-in/Support	▲	▲	▲	▲	▲	▲	▲	▲				▼	▼	▼	▼	

In the following chapter, I will further review these results and interpret these results to explain meaning and implications of these results. While the joint venture lifecycle was not a formal research question, I will first summarize results and provide an interpretation of the meaning of the lifecycle that emerged. By starting with a discussion of the lifecycle results and meaning, I provide a foundation for my discussion of the four research questions. Next, I will summarize results and describe meaning to formal and informal controls that emerged. Third, I will summarize results and interpret meaning for how leaders experienced trust. Lastly, I will describe the process used to build trust within the joint venture and discuss recommendations for future research.

Joint Venture Lifecycle

Based on my analysis and the results of the data, the Restorative Health joint venture passed through eight stages: Form business concept, Negotiation 1, Design, Implementation, Restructure 1, Restructure 1.1, Restructure 1.2, and Negotiation 2/Restructure 2. This lifecycle partially supports and partially refutes the lifecycle models of Kanter (1994) and Ring and Van de Ven (1993) that I reviewed in Chapter 2.

For example, Kanter (1994) used a marriage analogy to describe the five phases that alliances pass through: "Selection and courtship, getting engaged, setting up housekeeping, learning to collaborate, and changing within" (p. 99). In contrast, the Ring and Van de Ven (1994) lifecycle compares an alliance to an evolving partnership that follows an iterative process. According to Ring and Van de Ven (1994), inter-organizational relationships pass through stages of negotiation, commitment, and execution. Within each stage, individuals in the relationships make assessments based on the efficiency and equity of the relationships and make decisions whether to continue or discontinue the relationship.

While I found elements of both the Kanter and Ring and Van de Ven lifecycle models in the Restorative Health joint venture, other elements emerged that did not fit either model. For example, the Restorative Health lifecycle partially followed the linear courtship, engagement, and marriage approach described by Kanter (1993) model and anticipated some conflict between parties as the organizations learn to live together.

At the same time, the Restorative Health lifecycle followed Ring and Van de Ven's (1994) iterative cycle of negotiation, commitment, and execution as leaders made frequent structural changes to adapt to the changing environment and shape people's behaviors and attitudes towards the goals of the joint venture. In addition, in the center of each stage of Ring and Van de Ven's (1994) model, an assessment is made by individuals on the efficiency and equity of the relationship and a decision is made to continue or discontinue the relationship. At each stage of the Restorative Health joint venture, individuals from each of the three parties made their own assessments of whether the joint venture was efficient and equitable and made their own decisions to continue or discontinue their participation in the joint venture.

The Restorative Health joint venture lifecycle provides at least two new insights into the Kanter (1993) and Ring and Van de Ven (1994) models. First, while Kanter (1994) acknowledges that no two alliance relationships travel the exact same path, her model assumes that alliances generally follow five linear and overlapping phases and will not face a decision to continue or end the relationship until the end of the lifecycle. In addition, Kanter's (1993) model does not take into account unexpected events with wide-ranging negative impacts, such as the financial crisis that faced Restorative Health that took place immediately after launching the joint venture. These events could abruptly end the joint venture or require the joint venture to make dramatic changes that impact its lifecycle simply in order to survive.

Secondly, the Ring and Van de Ven (1994) lifecycle model assumes that as the organizations in the joint venture make collective decisions on negotiation, commitment, and execution on behalf of the people in their organization, the individuals in these organizations will agree, accept, and commit to the decisions made by the larger organization. However, individuals in each of the three partner organizations chose to commit to and embrace, accept and comply, or resist and withdraw in response to the decisions made by their leaders.

Formal Controls

As described in Chapter 2, organizations establish and use formal mechanisms such as formal rules, procedures and policies, reporting structure, staffing, and training as formal controls to monitor and reward desired performance (Das & Teng, 2001). These mechanisms help to create the explicit transfer of information that is predictable, regular, and codified in rules, procedures, and regulations (Inkpen & Currall, 2004).

Based on the interview data, three types of formal controls emerged: financial reward systems, organizational structure, and selection and placement of people. In the sections below, I will review the results from these types of formal controls, discuss how these results confirmed and refuted the existing literature, and discuss the meaning and implications of these results.

Financial reward systems

Equity ownership, base compensation, and incentive plans were financial reward systems that were designed, implemented, and revised by Restorative Health leaders to monitor and reward desired performance. However, while physicians worked side-by-side and performed the same work, this formal control did not translate into high trust during Restructure 1, 1.1, and 1.2 in part, because the physicians' reward systems were not common and consistent across the different parties.

In contrast to the case study, literature suggests many benefits can be achieved from the use of financial reward systems as formal controls. Several studies (Killing, 1983, Schaan, 1998, Kumar & Seth, 1998) indicate that appropriate compensation arrangements and incentive plans can motivate managers to work harder for the success of the venture, reduce the threat that managers will take actions contrary to the parent's interest, coordinate each partner firm's interests, and arbitrate in disputes among partners.

However, when Restorative Health created and managed different financial reward systems across the different parties, Central Health Care physicians perceived a lack of equity which significantly undermined trust. According to the equity theory of motivation (Adams, 1963), people in an exchange relationship have a strong need to maintain a perceived sense of equity in the relationship based on the inputs they supply and costs they incur. White and Lui (2005) explain,

> While an actor may evaluate the ratio of benefits to costs in absolute terms or by an internal standard, research on individual behavior shows that an actor's evaluation of this ratio is usually strongly influenced by his perception of other actors' ratios (p. 917).

Thus, this theory helps to explain the frustration and distrust that some Central Health Care physicians felt towards Atlas Group physicians over a perceived difference in financial reward systems while these physicians worked side-by-side and performed the same work. Even though a Restorative Health executive administrator met with and explained the logic of the different pay systems to some of the physicians who had concerns about the perceived pay difference, their perceptions and negative feelings did not change.

Despite the perceived inequity described above, Atlas Group and Central Health Care physicians who supported Restorative Health remained engaged and committed and

demonstrated trust in the larger joint venture. According to Das and Teng (1998), trust and inequity can exist simultaneously in some situations.

> . . . the relationship between trust and equity appears to go both ways – that is high levels of trust tend to encourage partners to tolerate short-term inequity or mutual forbearance. Given a certain trust level among partners, it is also apparent that extended periods or growing instances of inequity will create tension and strain existing trust. Therefore, for the sake of trust building, profit distribution needs to be kept on an equitable basis (p. 504).

Thus, this literature helps to explain how physicians from Great Plains University and Central Health Care who demonstrated trust and high commitment to Restorative Health tolerated the inequity in pay and incentives. However, while these physicians demonstrated tolerance and forbearance, their patience started to grow thin and trust wavered in the months leading up to Restructure 2/Negotiation 2 as they anticipated that financial rewards would be restructured to ensure common and equitable pay practices across all partners.

Organizational structure

Organizational structure was the second theme that emerged as a formal control. For the *staunchly supportive* group, organizational structure had an overall positive impact on trust. During the Design and Implementation stages, the structure of Restorative Health had a positive impact on trust. However, trust decreased during Restructure 1 due to the structural changes incurred from Restorative Health taking on Central Health Care's processes and technology systems. Trust increased during Restructure 1.1 and 1.2 as a new business line was created and then dissolved. While the structural changes announced during Restructure 2/Negotiation 2 positively impacted trust, groups were also somewhat uncertain if parties would fully keep their commitments and if the changes would lead to continued success for Restorative Health.

For the Central Health Care groups who actively opposed Restorative Health, organization structure of Restorative Health had a negative impact on trust during the

Implementation stage. Despite changes by leaders to restructure the joint venture to have a more positive impact for all groups, the structural changes during Restructure 1, 1.1, and 1.2 did not increase trust among the physicians and administrators groups at Central Health Care who actively opposed Restorative Health.

Over the five-year lifecycle, Restorative Health made five changes to its organization structure. While five structural changes within a five-year period may seem like too frequent a pace of change, this finding supports research studies that emphasize the need for flexibility and frequent structural change in joint ventures. According to Bamford et al (2003), the "structure of an alliance cannot stand still – it must evolve to adapt to changing conditions and needs" (p. 72).

In addition, Bamford et al (2003) advise managers that "An alliance is managing an open-ended agreement between two companies" (p. 70). Thus, while the organizational changes of Restructure 1, 1.1, and 1.2 were painful for all three parties, the changes facilitated the process to rebuild and strengthen Restorative Health so it could survive and become stable and profitable.

Selection and placement of people

Selection and placement of people was the third theme that emerged as a formal control. Within the *staunchly supportive* group, this control positively impacted trust from the Design through the Restructure 2/Negotiation 2 stages as leaders selected and placed people with unique skills and expertise into strategic positions at critical stages in the joint venture. For the group from Central Health Care who actively opposed Restorative Health, trust was negatively impacted during Restructure 1.1 when Dr. White was selected to lead the new Patient Care service line, but trust increased when the service line was dissolved and the Central Health Care

physicians who opposed Restorative Health reported to an administrator from Central Health Care.

Interview data and results in this case study support current research that suggests staffing of people in the joint venture is an important formal control. According to Kumar and Seth (1998), the top management positions in a joint venture can be filled with managers from "the parent's managerial pool or may be recruited from the 'external' labor market" (p. 585). In addition, Kumar and Seth (1998) recommend that staffing decisions should be made to "ensure that the joint venture's management team has the requisite skills to manage the joint venture effectively" (p. 585).

While the people selection and placement practices at Restorative Health were a formal control and supported the literature quoted above, their practices also differed from recommendations made by other researchers in the field. For example, Killing (1983) and Kumar and Seth (1998) recommend that organizations staff important leadership positions in a joint venture with managers from the parent organization. This can improve the information-processing capacity of the joint venture in three ways. First, managers from the parent organization can directly transfer the values, objectives, and 'ways of doing things' from the parent company to the joint venture. Secondly, the parent manager brings an informal network with other managers in the parent organization (Killing, 1983). Thirdly, managers from parent organizations who are placed in leadership positions within the joint venture will "more easily obtain resources necessary for its continued survival from its parents" (Kumar & Seth, 1998, p. 585).

While organizations can benefit by selecting and placing top leaders from the parent company into the joint venture, executive administrators at Central Health Care intentionally

chose to take a different approach and fill their top leadership positions in Restorative Health with people from outside of Central Health Care.

These and other selection and placement decisions proved to be pivotal in the evolution of Restorative Health. Rather than carry forward the values, objectives, and 'ways of doing things' held by the Central Health Care, executive administrators at Restorative Health received the charge from Central Health Care executive administrators to ensure that Restorative Health retained a vision, mission, values, and strategy that was different and separate from the parent organization. In addition, when executive administrators at Restorative Health were selected and placed in their executive administrator positions, trust increased with individuals in most parties because the Restorative Health executive administrators were truly neutral and only represented the interests of the joint venture, not those of one of the three parties.

Informal Controls

As stated in Chapter 2, organizations establish and use informal mechanisms such as "organizational norms, values, culture, and the internalization of goals to encourage desirable behavior and outcomes" (Das & Teng, 2001, p. 259). In this context, informal controls are intended to "reduce goal incongruence and preference divergence among organizational members" (Das & Teng, 2001, p. 259). Compelling vision/mission, relationships, and buy-in/support were three themes that emerged as informal controls in the current study. While extant research supports this finding, there is no evidence in the research literature that compelling vision/mission and buy-in/support are important sources of informal control. In the section below, I will review the results from these types of informal controls, present the literature that supports relationships as an informal control and expand the definition of informal controls to include compelling vision/mission and buy-in/support.

Relationships

Relationships were a form of informal controls that impacted trust for both groups. For the *staunchly supportive* group, relationships positively impacted trust during the Form Business Concept through Implementation stages. During Restructure 1, trust somewhat decreased as some Central Health Care administrators and physicians did not view some Atlas Group physicians as playing on the "same team." However, the impact of relationships on trust increased from Restructure 1.1, 1.2, and 2 as administrators and physicians worked together and reached across party boundaries to help each other without expectation of reward or return.

In contrast, relationships between Restorative Health and the Central Health Care group members who actively opposed the joint venture had a negative impact on trust during the Implementation through Restructure 1.1 stages. During this time, some Central Health Care physicians did not refer patients outside of Central Health Care system and complained about delinquent behavior of physicians outside of Central Health Care while their own physicians demonstrated some of the same delinquent behaviors. During Restructure 1.2, the impact of relationships on trust improved as Restorative Health executive administrators reached out to Central Health Care physicians and administrators not associated with Restorative Health in an effort to help them succeed in their separate line of business.

The results described above support current literature and describe three ways in which relationships play a role in informal controls (Inkpen & Currall, 2004, Garcia-Canal, Valdes-Llaneza, & Arino, 2003). First, during the early stages of the joint venture, the Great Plains University department administrator formed close personal relationships with Atlas Group physicians and Central Health Care executive administrators. These relationships helped the

leaders to take the leap of faith needed to launch the joint venture and to address and work through conflicts. According to Adobor (2006),

> Personal relationships may also be of great consequence as the alliance unfolds. During the early stages of an alliance, partners are most likely still feeling each other out; major commitments have not yet been made, and the partners may be looking for any signals to either make commitments or take a step backward. This is the time when personal relationships could matter most, as they can provide the measure of comfort necessary to prompt partners into taking a leap of faith, something that is required for the growth of the alliance (p. 476).

Secondly, personal relationships were important in this case study to address and work through conflict between individuals and parties. For example, a Restorative Health executive administrator had a personal relationship of trust and respect with most individuals in the different partner organizations. As a result, he was able to mediate conflicts and ask them to forgive each other for mistakes and offensives. Literature supports the importance and significance of relationships among leaders in the joint venture which serves as a "safety net which protects the alliance from self-destructing when the business is under performing or when expectations are not being realized" (Spekman, Isabella, MacAvoy, & Forbes, 1996, p. 352). In addition, Kanter (1994) stresses the importance of relationships as an informal control to address and resolve conflicts,

> Many strong interpersonal relationships help resolve small conflicts before they escalate. "There really is no good system for working out problems except through personal relationships," observes a European manager experienced in transatlantic relationships. "If you don't establish good rapport with your counterparts, you haven't got a prayer of making it work. Formal structures of decision making don't do anything for you unless you've got the relationships to start with" (p. 106).

Finally, during Restructure 1, 1.1, and 1.2, some relationships and trust between physicians in Atlas Group, Central Health Care, and Great Plains University were strained. However, other relationships during this time were also improved and trust increased through "spontaneous interactions" of physicians who frequently volunteered to help physicians from

another party without expectation of return or financial reward (Das & Teng, 1998). In summary, the current case study provided further support to theoretical propositions made in the literature that relationships serve as an important informal control.

Compelling vision/mission

For the *staunchly supportive* group, the compelling vision/mission of Restorative Health was an informal control that had a constant and positive impact across all stages of the joint venture. Conversely, this informal control consistently had a negative impact on trust during the Restructure 1, 1.1, and 1.2 stages for the Central Health Care group who actively opposed Restorative Health.

Thus, the Restorative Health vision/mission was an informal control that impacted the development of trust and success of the joint venture in two ways. First, while each of the three parties had different reasons for joining Restorative Health, all three shared the common and compelling vision/mission to create a Center of Excellence as a great place to work, great place for patients, a great place for community education, and a great place for educating physicians. Through this common vision/mission, most physicians and administrators who worked at Restorative Health found strength and unity to endure the hardships and overcome obstacles until they experienced success.

Secondly, a compelling vision/mission helped individuals transition from the norms, strategies, and culture they knew at their partner organization to the new norms, strategies, and culture of Restorative Health. The early stages of a joint venture can be challenging for people as different norms, strategies, and cultures collide as partner organizations come together. Plus, during this time, people can experience large amounts of uncertainty as prior organizational

structures no longer apply and new organizational structures may not yet exist (Das & Teng, 2001).

Based on the results from the case study and in support of the research literature on joint ventures, the creation of and continued use of a compelling vision/mission helped to give a new identity of values and culture to the new joint venture, reduce ambiguity and complexity, and engender trust among individuals and parties. While a compelling vision/mission is not currently acknowledged in the research literature as an informal control, the case study suggests that compelling vision/mission is an important component of informal controls and warrants further research to validate this proposition.

Buy-in/Support

Buy-in/Support was the third theme that emerged as an informal control. Among the *staunchly supportive* group, buy-in and support had a constant and positive impact on trust through all stages of the joint venture. Conversely, buy-in/support for the joint venture had a constant and negative impact on trust for the Central Health Care group who actively opposed Restorative Health from Implementation through Restructure 1.2. As noted earlier in Tables 11 and 13, the level of buy-in and support in favor of Restorative Health varied across four groups within the different partner organizations.

According to Kubler-Ross (1997), Bridges, (2003), and Weisbord (2004), people pass through different psychological stages in a cycle as they react to change and loss. While these models of change are well-known and accepted, results from the Restorative Health case study did not confirm these three models. According to the case study, people's individual reaction to their organization's decision to join Restorative Health did not seem to follow the traditional stages of loss and transition. Instead, participants' attitudes towards the change remained fairly

constant in one of three categories: commit and embrace the change, comply and accept the change, or resist the change. These categories are described further below.

Commit and embrace. From the start and throughout the joint venture, the commitment level of the *staunchly supportive* group was strong and consistent as they embraced the values, culture, and goals of Restorative Health. This group consisted of Atlas Group physicians who had a long history working together prior to Restorative Health along with executive administrators from Restorative Health and some physicians from Great Plains University and Central Health Care. Levels of commitment were high in the Atlas Group because they were some of the original founders of the joint venture business concept and they invested large amounts of their personal money in the joint venture. In addition, commitment levels were high in the physicians that joined from Central Health Care and Great Plains University.

Comply and accept. Some administrators and physicians at Central Health Care and Great Plains University agreed to support the joint venture while they participated in the Design and Implementation stages. However, following Implementation and Restructure 1, these Central Health Care administrators and physicians showed a lack of commitment by accepting and complying with the change in the short-term and on the surface, but failed to accept and make a deeper and long-term commitment to the joint venture. As a result, these people sat on the fence with their commitment and then withdrew their support when challenges emerged.

Resist and oppose. Some administrators and physicians at Central Health Care actively resisted and opposed their organization's support of Restorative Health for two main reasons. First, while executives and some department administrators at Central Health Care were involved in the Negotiation stage and supported the vision and mission of the joint venture, some department administrators did not adequately share this information with their physicians in the

medical department and report back to executive administrators in a timely manner about concerns their physicians had about joining Restorative Health. As a result, some department-level physicians at Central Health Care immediately opposed their organization's decision to join Restorative Health and refused to move their practices to Restorative Health because they did not feel their voices or concerns were adequately heard. This finding supports the theory that people support what they help create (Beckhard, 1969; Wooten & White, 1999).

Second, some administrators and physicians at Central Health Care opposed their organization's involvement in the joint venture because they believed the partnership was unfair and unbalanced. As with the perceived pay inequity with the *staunchly supportive* group, equity theory can also be applied to understand the resistance demonstrated by the group from Central Health Care who opposed Restorative Health. According to equity theory, firms in a joint venture who contribute the most resources (tangible and intangible) should get the most back in return. In addition, people in exchange relationships have a high need to maintain their sense of equity (Adams, 1963).

Some Central Health Care administrators and physicians inside and outside of the medical department opposed their organization's support of the joint venture because they perceived a great inequity in the joint venture relationship. For example, during and after the financial crisis, Central Health Care executive administrators provided a large amount of financial resources to keep Restorative Health open and operating until the joint venture became stable and profitable. As a result, financial resources that went to Restorative Health were diverted from other departments and programs within Central Health Care. Thus, some Central Health Care administrators and physicians who did and did not work with Restorative Health

perceived a high degree of inequality and actively opposed the partnership with Restorative Health.

In addition to equity theory, this case study result also supports the equity component of Ring and Van de Ven's model (1994). Their model states that throughout the lifecycle, parties make assessments and decision to continue or discontinue their participation in an inter-organizational partnership. Parties will continue their participation if they determine that the partnership is efficient and equitable. Administrators and physicians from Central Health Care who withdrew and actively opposed their organization's participation in the joint venture did so because they did not perceive the partnership as equitable.

How Leaders Experienced Trust

As stated in Chapter 7, leaders experienced trust at multiple levels. Trust levels were high among the *staunchly supportive* group as they sacrificed and suffered together through the challenging times and could eventually celebrate the true friends and partners they had become and the successful joint venture they created together. However, while trust existed within this group, distrust existed between Atlas Group and Central Health Care because they formed and held negative perceptions of each other. In essence, trust was low between both groups because neither was willing to invest much effort and look beyond the negative perceptions or try to understand the other group's perspective. In addition, both groups distrusted each other because they perceived that the other party was responsible for their separate financial losses and that only one side could succeed at the expense of the other side. Despite the financial and relationship challenges, trust increased as the joint venture began to experience some financial success. In addition, trust increased as Restorative Health executive administrators gained

credibility with the new team of executives at Central Health Care and negative perceptions began to change.

Thus, leaders experienced both trust and distrust over the lifecycle of the joint venture. Leaders of all three parties experienced trust, and leaders of Atlas Group and Central Health Care experienced distrust as they encountered negative perceptions of each other and overcame that distrust as Restorative Health experienced financial success and as Central Health Care hired new executive administrators.

The results described above were supported by literature regarding Research Question 3 that sought to better understand how leaders experience trust. While leaders experienced feelings of trust and distrust over the lifecycle of the joint venture, these feelings varied according to which groups interacted with each other. In the following section, I discuss how leaders in three of the most poignant relationships did or did not experience trust.

- Mutual distrust between Atlas Group and Central Health Care department administrators and physicians who actively opposed Restorative Health
- Atlas Group distrust of Central Health Care executive administration
- Trust between Atlas Group and the *staunchly supportive* group

Mutual distrust between Atlas Group and Central Health Care department administration and physicians who actively opposed Restorative Health

From the early stages of the joint venture, some physicians and department administrators from Central Health Care did not trust Atlas Group. They formed negative perceptions of Atlas Group based on negative information and rumors they received from external physicians and organizations that were in direct competition with Restorative Health. Some of these negative

perceptions were reinforced as the physicians worked together side-by-side at Restorative Health.

By the same token, Atlas Group carried negative perceptions about department administrators and physicians at Central Health Care who did not support Restorative Health. Atlas Group viewed these people as contributing to the financial crisis of Restorative Health and promoting the belief that Restorative Health should be closed because the joint venture competed with Central Health Care's medical department and drained resources away from Central Health Care's medical department.

Atlas Group's distrust of Central Health Care executive administration

Atlas Group entered into the early stages of the joint venture lifecycle with initial trust in the executive administrators at Central Health Care. However, this trust was quickly lost as Central Health Care did not deliver on their commitment to provide physicians and patients to Restorative Health and as Central Health Care stepped in to restructure the joint venture following the financial crisis. Atlas Group's trust of Central Health Care executive administration remained low during Restructure 1, 1.1, and 1.2 as Atlas Group questioned Central Health Care's commitment to the joint venture or if Central Health Care withheld support in hopes the joint venture would be forced to close. Atlas Group perceived Central Health Care executive administration as a "big gorilla" that made restructuring changes to Restorative Health that were too heavy handed and too swift. While trust improved after Restructure 2 as the distance on the organization chart increased between Atlas Group and Central Health Care executive administrators, Atlas Group remained somewhat skeptical whether they could trust Central Health Care executive administrators.

Trust within Atlas Group and the Staunchly Supportive group

While the two previous sections described groups that Atlas Group distrusted, Atlas Group experienced trust throughout the lifecycle towards members of the *staunchly supportive* group. To a large degree, this trust was based on the informal controls of relationships, compelling vision/mission, and buy-in/support described earlier in the case study. By the same token, some distrust emerged among the Atlas Group and the *strongly supportive* group regarding the perceived inequity from the different financial reward systems. However, this distrust decreased and trust increased after Restructure 2 when all parties accepted a common and more equal financial reward system.

In addition to the perceived inequity issue described earlier, a variation in the levels of risk that Atlas Group placed in the joint venture compared to physicians from Great Plains University and Central Health Care can also explain some of the variation in trust. For example, physicians in the Atlas Group believed so strongly in the business concept that they left their previous employer in search of partners to help form the joint venture and invested their own money to help launch the joint venture. In contrast, while some physicians at Great Plains University and Central Health Care supported the joint venture, they personally held less risk in the joint venture. While these physicians joined and supported the joint venture, they held less risk because their employers put in a portion of the investment money, and the physicians from Central Health Care and Great Plains University could always fall back on their employers for employment if the joint venture failed or other partnered pulled out. In contrast, each of the Atlas Group physicians invested a significant amount of their own money, lost their original investment, and would not have had an employer to support them if the joint venture had closed. Once Restorative Health was stable and financially strong, the level of performance and

relational risk, uncertainty, and subsequent level of trust required was greatly reduced. Thus, these elements would not be required to the same degree for other physicians or health care organizations that chose to join Restorative Health in the future.

Forgiveness and trust

While trust and distrust existed among physicians and the partner organizations, executive administrators at Restorative Health advocated and modeled several virtues over the lifecycle that included courage, hope or optimism, honesty or integrity, and forgiveness. Literature supports the use and development of these virtues to help individuals, groups, and organizations increase resilience and buffer against dysfunction and illness (Seligman & Csikszentmihalyi, 2000). In the section below, I describe examples from the case study that supports and contrasts the literature on the use of forgiveness to increase trust.

Over the lifecycle of the joint venture, Atlas Group and Central Health Care did not reach feelings of forgiveness to the other party for the actions and events that injured the other. Literature supports the reluctance to forgive others and explains how a lack of forgiveness can hinder the development of trust.

According to Argandona (1999),

> . . . trust is a gift, not an exchange, and so the ability to accept, fight and forgive mistakes must be present. Gratitude and forgiveness are the cornerstones of trust (p. 224).

However, when I asked an Atlas Group physician if his group felt any forgiveness towards Central Health Care administration for the negative impact they received from the joint venture, the physician responded that he can now "understand Central Health Care, but not forgive them." I received a similar response from a Central Health Care administrator who expressed feeling skeptical about forgiving Atlas Group for the negative impact Central Health Care experienced from the joint venture.

Their responses to my question and lack of willingness and readiness to forgive each other for events that took place many years ago intrigued me. Most researchers agree that forgiveness takes place when the offended party decides to let go of feelings of resentment, negative judgment, bitterness, and indifferent behavior in response to an offense (Enright, Eastin, Golden, Sarinopoulos, & Freedman, 1992). According to Pargament and Rye (1998) and Baumeister, Exline, and Sommer (1998), forgiveness is different from reconciliation, where someone forgives another in order to re-establish a relationship between two parties. In addition, these authors assert that people can forgive each other without wanting to re-establish a relationship with the offender or without having the relationship return to normal.

This insight from the literature helps to explain the relationships between Atlas Group and Central Health Care. Through the organizational changes in Restructure 2, Atlas Group became employed by Great Plains University. Also, through Restructure 2, Restorative Health became a more independent entity and no longer had a financial dependence on Central Health Care. As a result, the future success or failure of Restorative Health now squarely rested on the shoulders of the physicians and executive administrators at Restorative Health, not Central Health Care.

Through these changes, Atlas Group and Central Health Care executive administration and physicians and administrators at Central Health Care who opposed Restorative Health were more organizationally distanced from each other than ever before. Plus, because of their differences that emerged over the lifecycle, these groups did not want to re-establish their relationships or want the relationships to return to normal.

However, while the organizational changes of Restructure 2 helped Atlas Group and Central Health Care start to forgive each other, they still needed to abandon negative affect and

behaviors and embrace positive affect and behaviors towards the other party. According to Cameron and Caza (2002),

> Feelings of retribution and resentment are replaced with feelings of empathy and concern. Trust may not be present, but the motives of the forgiver are toward goodness for the offender (p. 39).

Throughout the joint venture lifecycle, executive administrators at Restorative Health worked with Atlas Group and Central Health Care physicians and frequently practiced "shuttle diplomacy" to try and facilitate the communication and forgiveness process. In addition, executive administrators at Restorative Health advocated and modeled forgiveness towards Atlas Group and people at Central Health Care who opposed the joint venture. According to a Restorative Health executive administrator,

> . . . I still like (Central Health Care) as people and as physicians and send patients to them all the time. I don't have a personal vendetta against them . . . I don't have a grudge against them even though they've caused me untold headache and extra work. I've even gone so far as to convince one of them to go into a leadership position in Central Health Care . . . and it's because the person really puts patients first.

Despite these efforts to promote forgiveness, leaders from other parties doubted if people could learn to forgive each other and forget the past as long as they were employed by their partner organizations.

> Great Plains University executive administrator: (Physicians) don't forget that stuff easily. It goes deep and their memories are long and I don't know whether it can be salvaged, those relationships.

> Central Health Care administrator/physician: . . . it's not until you're gone and other people like you are gone that want to make the friction and the uncomfortable parts of the merger - as long as they keep coming up and keep coming up, it'll be an issue. When the people who fester on that go away, then you're left with the good part and then, and only then, can the merger really flourish the way it should, provided that it should flourish. So, the naysayers and the people that have a problem with (the joint venture), a lot of them need to just be gone through attrition before some of the merger things really can thrive.

In summary, leaders from the joint venture and all three partner organizations experienced trust in different ways with different groups over the lifecycle of the joint venture. In this section, I discussed feelings of trust and distrust experienced by Atlas Group with other groups and efforts made by executive administrators to encourage groups to forgive each other to re-establish trust and wellness. While physicians in Atlas Group and Central Health Care were not ready to forgive each other for past mistakes, changes made by executive administrators during Restructure 2 was helping individuals in the Atlas Group and Central Health Care begin to replace negative emotions with positive emotions and slowly rebuild trust towards the other party.

Process to Build Trust within the Joint Venture

In my fourth research question, I sought to understand the process to built trust within a joint venture. After analyzing the data and themes that emerged from this case study, a general process and pattern appeared which described how trust was built at Restorative Health over the joint venture lifecycle. The list below describes the sequence and main events during the process and the corresponding stage within the lifecycle.

1. Assemble a core group of people/organizations who carry unique strengths, hold a common vision/mission, and could benefit from the synergies of the combined organization. These events took place during the Form Business Concept stage.
2. Share the vision/mission and combined benefits with the larger group of stakeholders to create buy-in/support and further refine the concept. These events took place during the Negotiation and Design stages.
3. Create, implement, and adjust formal controls to provide structure, support goals and shape behaviors and attitudes (fair and equitable financial reward systems,

organizational structure, and hire/place the best people). These events took place during the Implement, Restructure 1, 1.1, 1.2, and Restructure 2/Negotiation 2 stages.

4. Foster, promote, and adjust informal controls to help further shape behaviors and attitudes (compelling vision/mission, positive relationships, and positive buy-in/support). These events took place during the Implement, Restructure 1, 1.1., 1.2, and Restructure 2/Negotiation 2 stages.
5. Leverage informal controls to create unity and draw strength from vision/mission, overcome interpersonal conflicts, forgive individual weaknesses and mistakes, and endure challenging times until parties reach success. These events took place during the Restructure 1, 1.1, 1.2, and Restructure 2/Negotiation 2 stages and represent new insights to the research literature on joint ventures.

Key Insights from the Restorative Health Cases Study

The purpose of this research study was to understand factors that lead to successful strategic alliances, with specific application for joint ventures. By gaining additional insights and knowledge in this area, business leaders will be able to experience greater costs savings, more effective organizational designs, and increased support for middle and front-line managers. In addition, OD practitioners will be better able to help leaders integrate, create alignment, and facilitate the change process of the joint venture. In summary, I gained the following insights from the Restorative Health case study.

Design of systems and structures.

- Design financial reward systems that are fair and equitable across all parties for joint venture employees who work side-by-side and perform the same work to avoid perceptions of inequity.

- Design the organization structure of joint ventures for with flexibility and anticipate the need to change and adapt the structure based on internal and external factors.
- Design a joint venture to distribute an equal amount of risk across individuals and partner organizations to better establish and facilitate the development of trust.
- During the Design stage, anticipate and create plans to manage and mitigate unexpected events such as financial crisis, economic reversals, natural disasters, or untimely/unexpected death, illness or retirement of joint venture leaders that could dramatically alter the lifecycle of the joint venture.

Selection and placement of leaders

- Select and place executive administrators from outside of the parent organization to lead the joint venture when executive administrators of the parent organization want to create a joint venture with goals, culture, and values that are different from the parent organization.
- Select and place executive administrators from outside of the parent organization to lead the joint venture when tension and conflict exists between two or more parties and when executive administrators will be perceived as neutral with no loyalty to either party.

Compelling Vision/Mission

- Build and uphold a compelling vision/mission for the joint venture that can help unify individuals and organizations under the new joint venture and embrace the new values, strategies, and culture.
- Leverage a compelling vision/mission to help individuals and organizations draw strength to endure hardships and overcome obstacles.

Relationships

- Invest in and leverage relationships of trust among leaders to help individuals and organizations take the "leaps of faith" necessary to create a joint venture, resolve conflicts and overlook offenses, and rebuild trust through spontaneous interactions.

Buy-in/Support

- Recognize and accept that while some people may demonstrate a range of emotions as they process their reactions to an organizational change, other people may experience a single and sustained positive or negative emotional reaction to the change.
- Recognize and accept that while organization leaders can make decisions on behalf of the individuals in their organization regarding participation in joint ventures, the individuals can chose to commit and embrace, accept and comply, or oppose and resist joint venture decisions. Thus, leaders should engage stakeholders that will be impacted by the joint venture and involve them in the decision making process to increase understanding of joint venture goals and design and increase the probability of buy-in and support from all stakeholders.

By applying these practical implications over the lifecycle of the joint venture, business leaders and OD practitioners will facilitate the development of trust across individuals and organizations within the joint venture, and increase the probability of a successful joint venture.

Implications for Research

According to the literature review in this study, the majority of research on strategic alliances and joint ventures over the past two decades has focused on empirical survey methods and proposed conceptual frameworks. While these methods and models helped to build and

expand the body of knowledge, additional research is needed to further understand and explain the dynamics that create successful strategic alliances and joint ventures. In the section below, I identify three groups of questions where additional research is needed.

First, while Kanter (1994) and Ring and Van de Ven (1994) propose models on the lifecycles for alliances and inter-organizational partnerships, little is known about how organizational crisis and trauma impact a joint venture lifecycle and the development of trust. While the Restorative Health case study provides one example of how financial crisis deeply impacted one joint venture, additional research is needed to help leaders anticipate and lead through the increasing possibilities of crisis and trauma in today's global and tumultuous marketplace. In particular, how do leaders negotiate and structure contracts to plan for and mitigate organizational crisis and trauma, and can further research confirm or refute the use of compelling vision/mission as an effective informal control during organizational crisis and trauma?

Second, Restorative Health was a three-party joint venture whose individual partner organizations held diverse interests, values, and cultures. During my interviews, some administrators and physicians expressed concerns that the vast differences in backgrounds and interests of the three parties were too far apart since these differences almost prevented the three organizations from successfully working together and learning to trust each other. Additional research needs to be conducted to better understand if an upper limit exists around how diverse partner organizations can be and still succeed. Also, research should be conducted to develop and test assessment instruments and metrics around different areas of diversity to help potential joint venture partners' measure and understand the depth and breadth of their differences.

Third, while the partner organizations agreed to renegotiate and continue their joint venture, some administrators and physicians at Restorative Health were reluctant to forgive each other for past decisions, injuries, and outcomes. During my interviews, several people acknowledged that the personalities of many physicians and the medical profession, in general, represent a community of individuals who are very individualistic, competitive, and incapable of harmony. I found evidence of these traits primarily in the interactions between some physicians in the Atlas Group and physicians and administrators of Central Health Care who opposed Restorative Health and less evidence of these traits in the interactions of the physicians in the *staunchly supportive* group. These traits combined with the reluctance by some Atlas Group physicians and physicians and administrators at Central Health Care to forgive each other inhibited the development of trust and teamwork within the joint venture. Additional research is needed to determine if other professional populations are more collaborative and how the propensity to be individualistic and competitive or group oriented and collaborative impacts the development of trust within joint ventures.

As described in Chapter 3, the interpretive case study is an underutilized research method in the study of alliances and joint ventures. However, the lifecycle and evolution of trust is a dynamic phenomenon should be further studied using a case study methodology which provides in-depth understanding of this phenomenon. In addition, interpretive case study methodology will continue to help answer the "how" and "why" questions I outlined above.

There are several limitations to be aware of in this case study. By using the case study methodology, I do not make definitive claims about preferred courses of action. The ability to generalize the results from the case study will be limited to principles drawn from one case and should not be generalized to other cases (McMillan, 2004).

A second limitation is that while the case study methodology provided a rich and thick description of the phenomenon (Geertz, 1973), the final report of the research may be "too lengthy, too detailed, or too involved for busy policy makers and leaders to read and use" (Merriam, 1998, p. 42).

Finally, the case studies can oversimplify or exaggerate a situation and lead the reader to make inaccurate conclusions about the actual state of affairs. Thus, I remind the reader that the organizations in the case study were only a small slice or life and does not necessarily account for the whole (Merriam, 1998).

Conclusion

This study was designed to explore the role that changes in formal and informal controls play in the evolution of trust over the lifecycle of a successful joint venture. Restorative Health was a joint venture formed from three health care organizations in the Midwest United States. Over their first five years, the joint venture went through many ups and downs and proved to be both a fantastic match for my research criteria and a fascinating case to study this phenomenon.

Based on interviews with executive administrators, department administrators, and physicians across the three parties, results supported existing literature, shed light on new knowledge, and identified areas for future research. In particular, results confirmed the use of financial reward systems, organizational structure, and selection and placement of people as formal controls to shape attitudes and behaviors towards joint venture goals. While these formal controls were adjusted over the lifecycle of the joint venture, organizational structure and the selection and placement of people had an overall positive impact on trust while financial reward systems had an overall negative impact on trust.

In contrast, results confirmed the use of relationships as an informal control and compelling vision/mission and buy-in/support were identified as new forms of informal control. While relationships between individuals changed over the lifecycle and had a positive and negative impact on trust, compelling vision/mission and buy-in/support did not change over the lifecycle. Compelling vision/mission had an overall positive impact on trust and buy-in/support had both a positive and negative impact on trust.

Through these formal and informal controls, trust and distrust evolved among leaders over the lifecycle of the joint venture. Trust evolved among some administrators and physicians who actively worked together and supported the goals of the joint venture. Among this group, trust levels were high as they sacrificed and suffered together through the challenging times until the joint venture became stable and profitable.

Conversely, distrust evolved at a different level as some administrators and physicians at Central Health Care withdrew their support and actively opposed their organization's involvement in the joint venture. These feelings of distrust were largely driven by negative perceptions that the Atlas Group and Central Health Care formed and held about each other.

Towards the end of the Restructure 1.2, the level of distrust between Atlas Group and Central Health Care began to decrease as new executive administrators were hired at Central Health Care, the joint venture experienced growth and financial success, and as the parties anticipated positive changes from Negotiation 2/Restructure 2. While these changes created greater equity in the financial reward systems among the three parties and created organizational distance between Atlas Group and Central Health Care, a level of distrust continued to exist among some groups.

Based on my analysis and synthesis of interview data and results from the case study, I documented a five step process that Restorative Health used to build trust within their joint venture. This process began when leaders assembled a group of people who held a common vision/mission and held unique strengths that could create synergies for the combined organization. Next, leaders shared this vision/mission with their stakeholders to gain support and buy-in and further refine the concept. After gaining additional support and definition from their organizations, leaders created and implemented formal and informal controls to shape behaviors and attitudes. Finally, leaders monitored progress and success of the joint venture and adjusted formal controls as needed and leveraged informal controls to draw strength to endure financial challenges and overcome difficulties in interpersonal relationships.

In closing, this study added support to existing literature, expanded the literature with evidence of new forms of informal control and new insights into how trust and distrust evolve over the lifecycle of a joint venture. In addition, this study identifies additional research that should be conducted including how leaders anticipate and lead through organizational trauma and crisis in a joint venture, whether limits exist around the range of diversity that organizations will allow to work together well among joint venture partners, and what professions and industries best demonstrate a willingness to partner, collaborate and forgive each other in a joint venture partnership.

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Appendix

Appendix 1

Dear <INSERT NAME>,

You have been identified as a leader with first-hand experience and knowledge of the Restorative Health joint venture. Mike Willis, a Doctoral candidate at the University of St. Thomas, is conducting an organizational behavior research study to explore factors of successful alliances.

Our organization was invited to participate in the study, and on behalf of Mike, I request your participation in the study.

The study will include an on-site interview lasting approximately one to two hours. Your participation in the interview is voluntary. If you decide to participate, you are free to withdraw at any time.

If you are willing to participate in an interview, please contact Mike Willis at mjwillis@stthomas.edu by <INSERT DATE>. Mike will work with <administrative assistant> to schedule the interviews.

The records of this study will be kept confidential. In any sort of report that Mike will publish, he will not include information that will make it possible to identify you in any way. He will be the only person with access to the records that he creates (including audio recording and notes from interviews), and he will destroy the records after the research study is complete.

Sincerely,

<INSERT NAME>

Appendix 2

CONSENT FORM
UNIVERSITY OF ST. THOMAS

Success Factors in Strategic Alliances
B09-124-02

Dear Participant,

My name is Mike Willis and I am a doctoral candidate at the University of St. Thomas. I am conducting a study about success factors in strategic alliances, and I invite you to participate in this research. You were selected as a potential participant because you currently participate or have participated in the negotiation, design, and/or implementation stage of the alliance. Please read this form and ask any questions you may have before agreeing to be in the study.

Background Information:

The purpose of this study is to gain insights and better understand the factors that lead to successful alliances.

In particular, this study will explore the following questions:
How do leaders experience trust during each stage of the alliance?
What roles do formal controls play in influencing the establishment of trust during each stage?
What roles do informal controls play in influencing the evolution of trust during each stage?
What is the process to build trust within the alliance?

By gaining greater insight and understanding to these questions, leaders will be more knowledgeable and successful in designing and implementing alliances.

Procedures:

If you agree to be in this study, I will ask you to do the following things:

1. Meet with me, face-to-face when possible, during normal work hours in a conference room and answer open-ended questions about your experiences in the lifecycle of the alliance. Interviews will be audio recorded for data analysis purposes. Please allow approximately one to two hours for the interview.

   While interviews will be scheduled during regular working hours, some interviews may be scheduled during the early morning, late afternoon, evening, or across multiple times in smaller time blocks, if necessary, to accommodate the participants' work schedules.

You will have the opportunity for a short break if the interview goes beyond one hour. If you need to respond to an urgent phone call or work issue before or during the interview, I will work with you to reschedule the full or remaining balance of the interview.

I will work with the executive administrative assistant of the sponsoring organization to schedule the interviews. Names of participants to be interviewed will be confidential. Interviews will be held in a private conference room that will maintain the confidential and anonymous nature of the interviews. You may be invited to participate in a follow-up interview.

2. After the interview, you may be invited to review and validate notes and themes that emerged during the interview. Review and validation of interview notes should take approximately 30 minutes.

Risks and Benefits of Being in the Study:

There are no risks involved in this research project. You can decide what experiences you will share and you can choose to stop the interview at any time. Should you decide to withdraw, the data collected about you will not be used.

The benefit you may gain from participating in the study is an opportunity to reflect on your experiences and gain insights into these experiences.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. I will be the only person with access to the records that I create (including audio recording and notes from interviews), and I will destroy the records after the research study is complete.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the alliance or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time. Should you decide to withdraw, data collected about you will not be used. You are also free to skip any questions I may ask.

Contacts and Questions

You may ask any questions you have now. If you have questions later, you may contact me at 763-442-1957 or mjwillis@stthomas.edu. My research advisor is Dr. Rama Hart and she may be reached at 651-962-4454 or rkhart@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to audio record the interview.

_____ _____

Signature of Study Participant **Date**

_____

Print Name of Study Participant

_____ _____

Signature of Researcher **Date**

Appendix 3

Interview Guide for Semi-Structured Interviews

1. General Information

   Name:

   Date and time of interview:

   Parent organization:

   Position within the parent organization:

2. General Experience with Joint Venture

   Which stage(s) of the joint venture did you have direct experience and involvement:

   Negotiation, Commitment, and/or Execution.

   Overall, do you consider the joint venture to be a success?

   Describe your position/role within each stage of the joint venture.

3. Formal Controls:

   How were formal controls (i.e., legal contracts, policies, and procedures) used during the negotiation, commitment, and implementation stages of the joint venture?

   How did a reliance on formal controls change over the lifecycle of the joint venture?

   How did this change impact the development of trust between firms in the joint venture?

4. Informal Controls:

   a. How were informal controls (i.e, norms, shared values, personal relationships) used during the negotiation, commitment, and implementation stages of the joint venture?

   b. How did a reliance on informal controls change over the lifecycle of the joint venture?

   c. How did this change impact the development of trust between firms in the joint venture?

5. Other Factors in Strategic Alliances

   How were decisions made between the firms?

How was conflict addressed and resolved?

What role did firms keeping commitments play?

What role did learning play in the joint venture?

What role did relationships play in the joint venture?