Teaching Negotiating Skills in the Family Medicine Center

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Teaching residents how to come to terms with their patients over issues such as "what is wrong" and "what needs to be done" is one of the daily challenges of precepting in family medicine. Difficulties inherent in any two-person negotiation are discussed and related specifically to the physician-patient relationship. A methodology for teaching negotiating skills is suggested. The method involves the preceptor asking the resident a number of questions that mimic a successfully negotiated physician-patient interaction. The technique allows the preceptor to identify weaknesses in the resident's abilities at the negotiating process and exposes the resident to statements that make for successful negotiating between physician and patient. Examples of weaknesses in residents' negotiating styles are described and specific recommendations for preceptors are provided.

Precepting in the family medicine center provides many challenges which often revolve around patients who have frustrated, angered, or overwhelmed their resident physicians. Residents commonly approach their preceptors with problems such as, "I've been seeing Mr. Smith for six months now. When he first came in I thought he had a simple problem. But every time I take care of one problem, he comes up with a new one. To tell you the truth I'm getting tired of seeing him," or "Last week I saw Mrs. Brown and we both agreed she needed more counseling. Today she didn't keep her appointment and when I called back she said she had changed her mind about the counseling." The purpose of this paper is to suggest that these types of challenging problems often reflect the difficulty physicians in training have in negotiating with their patients. This paper will discuss the concept of negotiation as it applies to the physician-patient relationship and will provide practical suggestions for the preceptor who is daily confronted with the complications of physician-patient interactions that have not been appropriately negotiated.

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Negotiating in the Physician-Patient Relationship

Webster defines negotiating with a disarmingly simple phrase, "to talk over a problem in the hope of reaching an agreement." For the physician and his/her patient the words mean coming to terms with at least three aspects of their relationship: agreeing about what is wrong, agreeing about what is to be done, and agreeing in what way responsibility will be divided in taking care of the patient's problem. While the process appears straightforward, it is in fact one of the most difficult skills that physicians need to master and preceptors need to teach.

Consider for a moment the concept of what is wrong with the patient, as it is negotiated between physician and patient. Physicians generally conceptualize the answer to this question in the form

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of a disease. For the sake of efficiency and because of their need to put closure on their interactions with patients, physicians often translate the question into "what disease does the patient have." But for the patient "what is wrong" may have a very different connotation. While the physician may assume the patient is asking for a name for his problem, the patient may, in fact, be seeking relief of a major symptom, relief of anxiety associated with that symptom, reassurance that he is not responsible for the condition that he is in, or simply assurance that the symptoms do not constitute a serious problem.[1] Patients frequently approach physicians with expectations that go beyond the diagnosing of medical disease.[2] These expectations frequently are not recognized by physicians, particularly physicians early in their training. For example, it is well known that many people who visit physicians are lonely, unhappy individuals who do not feel supported in their daily lives. Subsequently, a common request that physicians receive from their patients is to "be a supportive and caring person to me."

As with the question of "what is wrong with the patient," the queries about "what to do and who is responsible for doing it" are equally problematic when physicians and patients fail to explicitly discuss these issues. Patients frequently make comments that suggest they believe their physicians can make their problems go away. Physicians in training often enter into this type of relationship without realizing that they are doing so. For example, patients come to physicians with problems that are the result of years of personal excesses, such as overeating and lack of exercise, with the hope that a physician can eliminate the consequences of these excesses. Needless to say the physician who enters into this type of relationship with a patient, without making it clear that the responsibility for change is essentially the patient's, is likely to be quickly frustrated.

Problems of negotiating are not limited to misperceptions on the part of the patient. Physicians can become seduced or intimidated by patients who expect their physicians to take primary responsibility for their problems. Physicians in training commonly enter into relationships with patients that are at least in part based on the patient's ability to flatter or frighten the physician into the position of taking major responsibility for solving the patient's problem. Physicians in training tend to hear the explicit request from these patients, "help me," but fail to hear the implicit one, "be responsible for me."

The purpose of these preliminary remarks concerning how patients and physicians negotiate or fail to do so is to point out that this is a complicated process and one which usually does not come naturally to physicians. The point is not so much that physicians need to learn to negotiate with their patients since this, in fact, occurs as soon as physicians enter the room and greet their patients. The problem is that many physicians, particularly those in training, tend to negotiate with their patients through implication and innuendo, taking for granted that they and their patients agree on issues such as what is wrong and who will take responsibility for solving the problem.

Teaching Negotiating Skills

It is preferable to base the teaching of any medical skill on a real patient-physician interaction and, ideally, one which the preceptor has observed. This is particularly true of the various communication skills residents need to learn as part of their training. The word *negotiate* is used to mean the type of interaction occurring between a physician and a patient that allows them to come to mutual understanding and agreement on the nature of the patient's problem and the solution to that problem. The particular technique described here has elements of both the Socratic method and the modeling theory. The technique is Socratic in that the preceptor asks the resident a series of questions which parallel the type of questions that a physician who is skilled in negotiating might ask his patients. It is also based on modeling theory in that, ideally, the resident learns to use the questions asked by his preceptor of him in his future interactions with patients. While the technique can be used to teach any communication skill, the examples here will refer only to preceptor questions that exemplify explicit negotiating skills. Some of the specific questions preceptors might ask residents that demonstrate this negotiating style are as follows:

1. What does the patient think is wrong with him today and how do you know that?
2. Why do you think this patient came to you specifically today?
3. What do you think the patient wants most

from you today and how do you know that?

4. Did you tell the patient what you thought was wrong and did this differ from his notion of the problem?

5. Does the patient understand what you can and cannot do about his problem?

6. Does the patient understand the amount of responsibility he will have to take in the treatment of the problem?

7. Does the patient understand how long the treatment will take, how much it will cost, and any negative effects of the therapy?

8. Was there anything about the patient or his request that made you think he may not comply with the recommended treatment, and did you make the patient aware of your concern about this?

Approaching the resident with these kinds of questions not only allows the preceptor to find out how well the resident and the patient have negotiated, but also serves as a model for the types of exchanges that occur when physicians and patients share with each other their thinking about the patient's problem. In the ideal situation, the preceptor has already observed the particular patient-physician interaction and has had his own impression of how well the resident and the patient negotiated the problem. Based on the preceptor's observation of that interplay, and the resident's responses to the questions posed by the preceptor, hypotheses concerning that resident's negotiating skills may be generated. The following exemplify the types of problems preceptors have identified using this technique.

1. *The resident who did not hear the patient's problem.* A resident was observed during an eight-month well-child check. During the course of the examination the patient's mother asked the physician why her baby had a soft spot on the top of his head. Rather than identifying the mother's concern, the resident gave her an explanation of the closure of the fontanelles which included a description of calcium and phosphorous metabolism. When the preceptor asked the resident what he believed the mother's concern was, he said rather sheepishly that he thought she was just curious. It was later discovered that the mother sought another physician and had a similar line of questioning.

2. *The patient who needed a friend.* A senior resident who was most interested in doing psychotherapy agreed to see a young woman for one hour each week for "psychotherapy." The patient's diagnosis had previously been chronic dependent personality disorder with anxiety and she had seen multiple physicians in the past. After three months of therapy the resident approached his preceptor saying that he felt that therapy was going nowhere and that he did not know what to do with the patient. The preceptor observed the next visit between this resident and the patient and came to the conclusion that the patient was a lonely, unhappy woman who received most of her social interaction during the week from this visit with her physician. On questioning the resident in the manner described above it became clear to the preceptor that the resident wanted to do psychotherapy while the patient wanted someone to talk to for what was little more than friendly chitchat. Following this discussion with the preceptor the resident met with his patient and after extensive negotiation they agreed to meet every two weeks for 20 minutes for what was then labeled "supportive psychotherapy."

3. *The woman who did not come back.* A young married woman was seen by a resident and it became obvious during the course of their discussion that the major problem was with her marriage. The resident identified this and suggested she and her husband return for marriage counseling. The patient felt that this was appropriate and a time was arranged. The couple never came back and when the physician called the patient she said that she had changed her mind about the need for counseling. On hearing this the preceptor asked the resident what type of a contract she had arranged with the patient; the resident's answer was simply that they had agreed to do marriage counseling. When the preceptor questioned the resident concerning the possible length of therapy, the expense of therapy, and the demand that the patient and her husband play an active role in treatment, the resident said that none of this had been specifically discussed with the patient. Recently this resident has successfully negotiated with other patients for marital counseling.

The types of discussions described here between preceptor and resident provide the preceptor with valuable information about the resident's negotiating abilities. The preceptor may identify specific or generalized areas of weakness in the resident's negotiating style and may formulate a

specific teaching plan based on his conceptualization of the resident's needs. The following is a partial list of some of the types of deficiencies preceptors have identified using this technique.

1. *Residents who do not recognize the patient's perception of the problem.* This is often the resident who sees his/her primary job to be the identification of disease states. He rarely asks and is not particularly interested in the patient's perception of the problem because in his mind this perception is irrelevant to the recognition and treatment of disease. He is likely to view emotional concomitants of disease as irrelevant and does not obtain information about current life stresses. He will not be able to tell his preceptor what the patient's expectations are, what he fears most, or what brought him in to see a physician today. The preceptor who identifies this type of problem must decide if the resident is simply unaware of the importance of the patient's personal understanding of the problem or if he actively avoids this type of interchange because he is afraid that it confuses and complicates his interaction with patients.

2. *Residents who fail to share their ideas with the patient.* This is the resident who may have trouble expressing himself generally or who may feel it inappropriate to share certain uncertainties or ambiguities with the patient. He may believe the patient wants a specific answer to his problem or that he wants the physician to "be the boss." He is likely to tell the preceptor that he does not share options or alternatives with patients. Preceptors can help this resident by asking him whether or not the patient understands what it is that he is supposed to do, and whether or not the resident asked the patient if he thought he could carry out the treatment plan.

3. *Residents who have trouble hearing the hidden request.* This resident may have trouble explaining to his preceptor how patients make him feel. He tends to hear the content of the patient's statement but misses much of the process. Preceptors may help this resident by asking questions such as, "Could you describe how the patient made you feel today," or "What was it that you think the patient wanted from you and how well do you feel you are meeting the needs of the patient?"

4. *Residents who negotiate unilaterally.* This resident often reduces anxiety in his otherwise complicated life by making it clear to his patients that he will set all the rules. The problem and the solution are based on his interpretation and anything beyond this is an unnecessary complication. He does not ask the patient what he thinks is wrong or what needs to be done because this adds "an unnecessary element to the interaction." A similar kind of problem occurs with the resident who has trouble differentiating patient requests and seems to try to be all things to all of his patients. All the patient has to do is mention a problem and the resident feels immediately that it is upon his shoulders to solve it. He does not ask his patient to prioritize his problems or whether or not he even expects the physician to solve his problems. This resident can be helped by the preceptor asking questions such as, "What do you think this patient wants most from you?" and "How much responsibility have you asked this patient to take for his own problems?"

These examples serve only to demonstrate the kinds of observations preceptors can make about their residents' negotiating abilities. It has been the author's experience that once problematic areas have been defined and the preceptor continues to use this method of questioning and answering, the resident himself begins to ask his patients these types of questions and the preceptor finds himself in the position of further encouraging and reinforcing explicit negotiating abilities. It should be mentioned for the sake of clarification that the author is not advocating that this type of interchange occur every time the preceptor meets his resident after seeing the patient. However, this type of interchange is appropriate when the preceptor is specifically concerned with identifying a resident's ability to negotiate with his patients and the time is available to do so. It is also appropriate to use some of these techniques on a day-to-day basis in order to find out, for example, how well a resident is identifying a patient's perception of his problems or how well he is identifying therapeutic options and conveying them to his patients.

References

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