Negotiation: A Fundamental Process in Family Medicine

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Negotiation, a common term in American society, is a process that can be especially useful to family medicine as a specialty that interfaces with many other clinical areas. The basic concepts of the negotiation process, including Maslow's need theory, terminology, and the three phases of the process (ie, planning, implementation, and follow-up), are applied to family medicine. A case study of a successful curriculum negotiation between family medicine and pediatrics is presented, and the use of need theory in the planning phase and during the strategic approach is analyzed. The negotiation process is also applied to faculty contracts, practice management training for residents, clinical teaching, and interdisciplinary relationships as indications of its broad usefulness within family medicine.

Negotiation is a term that conjures up images of George Meany and labor management disputes. Federal arbitrators, collective bargaining, strikes, and newspaper headlines, however, are not a part of most negotiations. At a family and personal level, negotiation is used in choosing a movie or vacation spot. Negotiation in public education has assumed a prominent role as school boards and organized education have resolved issues of salary, work conditions, curriculum responsibility, evaluation procedures, and even textbook selection and distribution.[1]

Negotiation is the action or process of conferring with another to arrive at the settlement of some matter. Negotiation is neither a game, nor a war with a goal of winning or losing. Successful negotiation results in a win-win situation.[2-4]

Negotiation is important to family medicine principally because family medicine is an interface specialty. Successful graduate training in family medicine demands cooperative relationships with the other major clinical specialties. Like it or not, family medicine does not totally control the education of its residents. A strong graduate program is dependent upon the successful negotiation of education objectives and methodologies with each of the individual specialties. Family medicine has

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a set of needs and values different from those of other major clinical specialties. Its concern for continuity, the family, cost containment, and the physician-patient relationship is at variance with subspecialty interests in ruling out an unusual disease, certainty of diagnosis, and desire to do technical procedures. These different value systems may result in conflict, which must then be resolved by negotiation.

Negotiation also has other important applications within family medicine. In patient care, the physician and patient negotiate their respective goals and often seek a compromise. Improved patient compliance may result from active and equal negotiation.[5] Teaching faculty negotiate expectations for a precepting encounter or a small-group seminar, and negotiate the objectives and evaluation of a particular hospital rotation. At the conclusion of a residency, negotiation for a job takes on primary importance to graduating residents.

This paper defines the basic concepts of negotiation as they apply to medical education, presents a case study in which this process was effectively used in a curriculum issue, and outlines new uses for this process.

Need Theory and Negotiation

In 1954, Maslow,[6] a social psychologist, presented a theory of motivation for human behavior. The most dominant of needs are called survival, physiologic, or homeostatic needs (food, shelter, water). On the second level of needs is safety or security (protection from physical or psychological threat, fear, or anxiety). Money in the bank, job security, and retirement plans represent concrete examples of safety needs. Love needs are the next highest level. Membership, acceptance, belonging, and feeling loved and wanted are examples of this level. Ego and esteem needs, the next level, represent a desire for reputation and prestige, plus respect and liking for self and others. Finally, the need for self-actualization can be defined as the need to do what must be done to become fully oneself—to develop one's individuality.

Several principles are postulated to explain behavior in terms of this hierarchy. First, the satisfaction of needs motivates virtually all human behavior. An individual must satisfy lower level needs before moving to a higher level. Finally, a need that is relatively fulfilled will not motivate behavior. Behavior, according to this theory, is a reaction to reduce specific need pressures.

The satisfaction of needs is at the center of all negotiations. The goal of all successful negotiations is for individuals or organizations to work cooperatively toward mutual satisfaction of needs. In the best of negotiations, the individuals or organizations have clearly identified and communicated their needs to one another and can therefore work toward a mutually beneficial outcome. In reality the definition and communication of needs is often much less clear. As a result, negotiators must rely on the communication skills of effective questioning, observation of nonverbal behaviors, and astute listening to diagnose the needs of the other parties involved in the negotiation.

Phases of the Negotiation Process

The negotiation process contains three major phases: planning, implementation, and follow-up. Table 1 outlines the major components in each phase of a negotiation.

Phase I: Planning

Planning for a negotiation is a continual process. Negotiation does not begin or end when a course or rotation is started or completed, a contract for clinical services is begun or ended, or an employee is hired or terminated. Negotiations are based on a relationship between individuals or organizations that respond to varying needs at different times in the relationship. Continual accumulation of information, definition of objectives, and clarification of needs are required. Negotiation is a life situation in which preparation is ongoing and doing the necessary homework is essential.

Prior to a negotiation, it is essential to define as clearly as possible one's own needs and those of the other negotiator. Accumulating necessary facts (ie, presented objective information) and verifying assumptions (ie, the supposition that something is true or false) facilitate the process.

Table 1. Phases of Negotiation Process

Phase I: Planning

- Develop necessary relationships over time
- Determine needs
- Accumulate necessary facts
- Verify assumptions
- Define issues to be negotiated
- Determine bottom line (ie, those items that are nonnegotiable)
- Role play various strategies prior to phase II

Phase II: Implementation

- Choose *best* strategy for situation to include:
  - General approach
  - Location
  - Introduction of multiple issues to avoid polarization on single issues
  - Linking of issues to facilitate compromise
- Determine needs of opponent through open-ended and probing questioning

Phase III: Follow-Up

- Write memorandum and send to other party a synopsis of negotiation
- Define further plans for evaluation or, if needed, continued negotiation
- Maintain appropriate relationship for further negotiations

Once accumulation and verification are accomplished, the issues to be negotiated can be defined based on needs, facts, and assumptions. At this time it is crucial to define the bottom line (ie, issues and needs that are not negotiable or open to compromise). Successful results in negotiation require intense preparation, both short-range and long-range, of the various planning steps.

The technique of role play is extremely useful in the preparation for an negotiation. It not only provides experience in presenting one's own needs but gives added insight into the needs of the other side.

Phase II: Implementation

Having completed the planning phase, the negotiators enter the implementation phase. Knowing the needs, facts, assumptions, and issues in consideration with the established relationships, the negotiator chooses the most appropriate strategy for initiating the negotiation. Consideration should be given to location of the negotiation, number and authority level of the negotiators, and general strategy for the negotiation process. Table 2 describes some common negotiation strategies.

Each side should determine ahead of time the style of negotiator for its team as well as for the other side. Styles of negotiators range from authoritarian (ie, I win, you lose) to collaborative (ie, I win, you win) to submissive (ie, I lose, you win). Since the successful outcome of a negotiation is based upon the ability of both sides to satisfy mutual needs, a highly authoritarian or submissive style may indicate that a negotiation is impossible until styles can be altered. If both sides have a

collaborative style, the negotiation can proceed to satisfaction of needs through compromise and resolution of issues.

Phase III: Follow-Up

After issues have been resolved, one of the negotiators must assume the responsibility of sending in a memorandum to the other party a synopsis of the decisions of the negotiation. The memorandum, which should be signed by the other party and returned to the initiator, provides a written document in which decisions have been clearly communicated and agreed upon, and should also include plans for evaluation of outcomes or continued negotiation. The memorandum serves as a summary statement and as a feedback loop to the planning process for subsequent negotiations.

Table 2. Negotiation Strategies

Strategy	Explanation
Surprise	Suddenly shifting your method
Feinting	Giving in on a point that is not especially important to you
Crossroads	Introducing multiple issues to avoid polarization and to assure everyone of winning on something
"Salami"	Taking one issue or component at a time so that the entire issue is eventually resolved
Forbearance	Waiting out the opposition by patiently holding off or suspending decision
Shifting levels	Changing your involvement with an issue to a different level such as redefining the problem or issue or changing the negotiator

Case Study

A complex negotiation between the Department of Pediatrics and the Family Medicine Program at Duke University Medical Center in February 1980 illustrates many of the steps discussed above.

The pediatricians requested *(need)* having one additional family medicine resident (year 2) in the nursery and moving the ward experience at the community hospital from the first year to the second year. A summary of the curriculum and planning is shown in Table 3.

The primary *needs* of the Family Medicine Program were to keep the ward experience in the first year, increase patient volume in the university ambulatory clinics, review the need for a second month of the nursery experience, and open up the entire pediatric curriculum for review based on the request for change. *Facts* about requirements for the pediatric education of family medicine residents were determined by the Residency Review Committee for Family Practice as well by resident and faculty input and opinion.

A series of *assumptions* were developed as discussion on the pediatric proposal developed. Clearly the pediatricians were overextended with three geographically separate nurseries to cover. In addition, the pediatricians appeared to be flexible in their request and seemed to respect the family medicine residents (or they would not have made the request). Finally, the request for residents to work an additional month in the nursery seemed more important (survival level) than the request for the ward resident to move from the first year to the second years (safety level).

A *bottom line* was developed after input from residents and faculty. An additional month on the nursery was judged valuable, especially given the high caliber of teaching and the increasing emphasis on obstetrics in the residency program. The change in ward experience was soundly rejected by residents and faculty alike. The most significant argument was related to resident recruitment and the atypical posture the pediatric curriculum would acquire. Finally, the Family Medicine Program strongly desired an enhanced patient volume experience in the clinic, and the program wanted to be included in the various outrider clinics staffed by pediatric residents and faculty. Previously, these clinics in underserved geographic areas were denied to family medicine house staff.

Table 3. Summary of Planning for Family Medicine—Pediatric Negotiation

Old Pediatric Curriculum	Proposed Pediatric Curriculum	Needs	Family Medicine Plan
PGY I Rotations	*PGY I Rotations*	*Family Medicine*	*Negotiable Issues*
1 month nursery	1 month nursery	Keep ward experience in PGY I	Doubling of nursing rotation
1 month ward	1 month clinic	Improve quality of clinic rotation	Improving quality of ambulatory experience
1 month clinic	1 month clinic	Maintain friendly alliance	*Bottom Line*
PGY II Rotations	*PGY II Rotations*	Maintain RRC pediatric requirements	Maintain PGY I ward rotation
1 month clinic	1 month nursery	*Pediatrics*	Maintain RRC accreditation
1 month clinic	1 month ward	Service in nursery	Maintain friendly alliance
	2 month clinic	More experienced family medicine residents on wards	

PGY = Postgraduate year
RRC = Residency review committee

The actual negotiation occurred among the Family Medicine Program director and three pediatricians in the small office of the senior pediatrician. After reviewing their proposal and list of requests, the negotiators agreed upon the nursery change. The pediatricians clearly stated that this was their most significant need and change. The concern about clinic volume and the need for additional outrider clinics was then addressed. The request by family medicine for two days per week of outside clinic experience instead of one day per week was accepted. Finally, the family medicine position totally opposing the switch of the pediatric ward experience to year 2 was revealed. A survival argument was advanced: The resulting pediatric curriculum would be very atypical and would put Family Medicine in a less attractive position for resident applicants. Some residents would not receive an inpatient pediatric ward experience until 24 months into the residency, yet they would be already caring for children in their panel of patients within the Family Medicine Center. The impact upon accreditation status, while still unknown, was introduced as a potential negative. After further discussion, both sides agreed that the pediatric ward experience would be reviewed again in one year.

In summary, extensive homework prior to the actual negotiation led to a clear bottom line and a win-win situation for the pediatricians and the Family Medicine Program. As a result of numerous internal discussions in which facts and assumptions were clarified, the single negotiator had a strong sense of support despite the three-on-one matchup at the negotiation. A friendly alliance was maintained to enhance further negotiations. The faculty in the Division of Family Medicine had looked at a wide range of alternatives and scenarios and had anticipated the issues using need theory to plan and outline a successful conclusion.

Discussion: The Practical Value of Negotiation

Negotiation skills play an important role in several aspects of family medicine education. The skills and concepts are as useful in the areas of faculty contracts and practice management training as they are in clinical teaching situations and the curriculum development examples presented above.

Faculty growth contracts are an increasingly popular tool to assist program directors in the overall management of program objectives and to help faculty clarify their individual goals and objectives. The development of each contract requires a negotiation between the needs of the individual faculty and those of the program director on behalf of the overall objectives of the program. For both the faculty members and the program to win, compromise will be necessary. If either the faculty member or the program director enters negotiation as a game, an adversary relationship is established. That kind of relationship, in conjunction with an imbalance of needs, will, in the long run, be destructive to both the individuals involved and the entire program.

The specific skills of negotiation can be taught to residents during a practice management course. For many residents, the best time to teach the concepts and skills of negotiation occurs when they are actively considering their next position. Appropriate role playing and discussion allows practice in a safe environment before moving into the job market. The resident has been in a subservient position for many years. In taking the next step into practice, fellowship, or teaching, the resident recognizes needs and assets and can enter the interview process from a position of strength and openness.

Clinical teaching activities provide daily opportunities for negotiation between teacher and resident toward mutual satisfaction of needs in the areas of patient care decisions, level of responsibility, and professional respect. In every teaching encounter the clinical instructor must attend not only to his or her needs for esteem and respect but also to the resident's needs for information, skill building, reassurance, and eventually independence. If teachers focus only on meeting their own needs, teaching then can occur without ever meeting the learners' needs. Effective questioning (eg, What do you need from me concerning this patient?) of the resident at the beginning of a clinical teaching encounter can clarify for the teacher what the resident needs. An intern who has been up for 36 hours needs sleep plus succinct, direct answers from an instructor, even if the instructor prefers to meet his own needs of self-esteem by lecturing the intern on the latest diagnostic and management issues of a particular patient problem.

Interdisciplinary negotiations, to be successful, often require a prior relationship. Negotiation across departments can be characterized by distrust and lack of understanding of each other's position and issues. As a result, a slow approach tied to development of relationships may be successful. The "salami" approach (Table 2) is a useful long-range strategy.

Several aspects of negotiation are worthy of re-emphasis. The time spent planning, gathering facts, testing assumptions, and clarifying needs is extremely valuable. Insufficient planning and preparation will probably lead to a less than satisfactory outcome. Successful negotiation takes place over a period of time and is generally not accomplished in a single session.

In summary, successful negotiation is not an accident. Careful attention to needs, assumptions, issues, bottom lines, strategy, process, preparation, and implementation will bring about a successful outcome.

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