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# Negotiating in a Medical Setting: The Art of Achieving Treatment Success

**Alan L. Nager\***

Department of Pediatrics, Division of Emergency and Transport Medicine, Children's Hospital Los Angeles, Keck School of Medicine, University of Southern California, USA

\*Corresponding author: Alan L. Nager, Division of Emergency and Transport Medicine, Children's Hospital Los Angeles 4650 Sunset Blvd, Mailstop 113 Los Angeles, CA 90027, USA, Tel: +323-361-4124; E-mail: nager@chla.usc.edu

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## Abstract

**Context:** Healthcare practitioners are rarely, if ever taught the skills of negotiating with a patient/family in a medical setting. There appears to be a "belief," that these skills are innate, practiced or learned in training programs or gained in actual medical practice. Yet, evidence suggests this is not the case. Reality dictates that a patient/caregiver may not always agree with physician recommendations.

**Methods:** Based on literature and research, a practical framework is described which outlines the advantages of structured, and phased negotiations.

**Objective:** To describe the phases, as a guide to achieving treatment success including: Convening, Opening, Communication, Negotiation and Closing.

**Results:** Due to misunderstandings, level of knowledge, emotional state, etc., a patient/family may refuse treatment, procedures or surgeries. Greater success can be achieved if the approach is organized, stepwise, collaborative and detailed.

**Conclusion:** A physician must negotiate treatments that are understood, meaningful, and acceptable. Having a formalized basis of interaction in a medical environment, will ultimately lead to treatment success. Through this prescribed methodology, the clinician can prepare and set goals, initiate and carry out interactions effectively, exchange and refine information, bargain and move toward closure, overcome obstacles and create agreement.

**Keywords:** Negotiation; Medical encounter; Bargaining; Agreement; Impasse

## Introduction

Macy's Initiative in Health Communication taught in medical school education years ago, but seemingly lost over time, suggests the following parallel steps occur in a healthy treatment environment: prepare for the interaction, open the dialogue, gather information, elicit and understand the patient's perspective, communicate during the examination, outline patient education, negotiate and agree on the plan and provide an authentic, sincere, realistic and agreed upon closing. Fundamental to this model is the essential element; to use relationship building skills and manage flow [1].

This article will focus on negotiation in Medicine by examining the challenges and issues that physicians face; how best to negotiate with patients and families, and how to achieve the best comprehensive and agreed upon solutions regarding patient care. The five phases of negotiation (Convening, Opening, Communication, Negotiation and Closing) provide a roadmap to a generically defined medical model. Although difficult to quantify, not following this framework clearly has implications with regard to individual or institutional satisfaction scores/rankings, medico-legal risks and deviations in practice, treatments, procedures, surgeries and outcomes.

## Convening

The convening stage assesses the client's willingness to participate in negotiation, determines the general need for the encounter, who will be the participants in the negotiation, the resources needed for success, and goals for the interaction.

In a medical environment, the negotiator (physician) determines the nature of the medical complaint, the reason the patient needs to be seen, previous interventions, and what attempts have already been made to mitigate the problem or disease. Conversations may be in person or *via* the phone with ancillary personnel who can set the tone, demeanor and expectations for the upcoming visit. First, the patient/family should be informed regarding the process, including how the proposed care will be delivered and by whom. Next, any financial arrangements can be discussed regarding payment, insurance and/or contractual obligations. Lastly, a

determination must be made regarding how best to convene, and how to conduct and support the medical treatment and/or interventions with culturally, ethnically and socially sensitive communication and behaviors.

Every medical encounter has a potential conflict requiring streamlined, organized and effective, bi-directional communication. All healthcare settings or organizations, regardless of complexity, must evaluate patterns that lead to success and not simply focus on singular events [2]. Pattern and process recognition within a system can guide interventions in a systematic way and help to reassess and reorganize well-intentioned, yet disorganized patterns. This may ultimately help in gaining an understanding in order to improve dysfunctional patterns and assist in gaining patient-centric priorities. Self-organizing behavior is the key in complex adaptive systems [3]. This means that when people interact routinely, study and learn from each other and adopt similar beliefs and respond appropriately over time, those behaviors become the "usual." Although responses from health care workers may be typical and common, a system re-assessment should routinely be conducted to determine if responses and processes are logical and appropriate, or if change must be implemented. The healthcare "environment" sets the tone for the patient encounter. Any processes carried out represent the health of the organization, the perceived importance placed on patient care, and the attitude upon which acceptance of medical care may be interpreted and understood.

## Opening

In the opening of a negotiation session, the negotiator states the ground rules for the encounter, verifies confidentiality, attempts to gain trust, seeks to understand client attitudes and emotion, builds rapport, and outlines the proposed process based on client needs, answers questions about the process, and sets goals for the meeting.

The opening in any medical setting, more than anything, must set the tone for the visit. The conversation should focus preemptively on demonstrating an open, honest and true concern for the patient and the struggles or challenges he/she is facing. Although the framework must, by convention, consist of those steps associated with history taking, performing a physical examination, then problem-solving and treatment, the conflictual or attitudinal nature of illness/injury and disease progression necessitate that matters be seen from the patient's view point, as that will be the best route to take in negotiating appropriate treatment interventions [4]. Botelho states that in a dynamic doctor-patient negotiation, 3 dimensions must be considered, a) content, b) relationship levels, and c) problem-solving phases [4]. Content describes the nature of the illness or injury, and involves the bi-directional give and take to gain a keen understanding of the patient's health concerns. Autonomy, power, control, and responsibility are those entities that define the relationship levels, or simply stated, how the physician and patient relate to one another during their conversation. The problem-solving phase includes those words that allow for the interchange of feelings and emotions that form the basis for relationship

building, agenda setting, assessments, problem clarification, management and closure.

Although the opening may appropriately blend into the communication stage, the opening sets this stage for active engagement, helps to manage expectations, provides the initial goal-setting and helps to establish rapport and gain trust for the clinician.

## Communication

A skilled negotiator focuses on words, intention, thoughts, meaning, and on the Triangle of Satisfaction (TOS) which takes into account the parties' emotional, psychological, extrinsic/social and economic/legal interests [5]. The negotiator is cognizant of his/her style, to give opinions (evaluative) or demonstrate an openness to dialogue (facilitative) [6].

The clinician interacting with a patient must honor complexity and ambiguity and allow the tools and techniques of opening him/herself to the "uncertain waters of human relating." [7]. When open, honest and direct dialogue become direct lines of communication, partnership and influence are likely to prevail. Talking out loud regarding the specifics of the medical complaint, such as *"I see you are having abdominal pain. These are my thoughts at this point after talking and examining you, and these are my treatment recommendations. But, I would like to discuss them, get your opinions and work together."*

Structured communication leads to a relational alliance between a clinician and patient/family members. Within this healthy therapeutic relationship, a cooperative arrangement is formed with essential components to include: demonstrating respect, having a genuine demeanor, being available, accepting individuality, showing self-awareness, having and maintaining boundaries, demonstrating understanding and empathy, and being supportive while promoting equality [8]. These facets prove and reflect that the personal and professional qualities of the clinician are essential to the foundation of a healthy therapeutic relationship. The human dynamics and relational understanding leads to the acceptance of medical treatment/interventions.

Having well-conceived communication and an appropriate stylistic approach allows the clinician to understand his/her audience's particular differences, ego-based motivations and rationale that may encourage openness and compromise that is necessary for the bargaining session. Communication, active listening and validation are essential to demonstrate that the clinician acknowledges the issues. It also shows that the clinician has visible empathy, and a true concern for collaboration, and that he/she is a willing partner able to listen, compromise (assuming the provision for providing standard medical care) and act in the best interest of the patient/family. *"I am so sorry you are in pain, and I fully understand how uncomfortable that can be. I am here for you to help and assist in any way I can to make you feel better."*

Nevertheless, in some cases despite best attempts to alleviate differences, communications may not achieve success

in a satisfactory or appropriate manner. Therefore, it is essential to view conflict as an inevitable part of the relational stance and one that can be corrected by incorporating phased negotiation. *"It does not seem like you are in agreement, so let us discuss your feelings so that we can move forward and get you the care that you need."*

## Negotiation

The negotiation phase involves preparation and goal setting, initiation of interactions, exchanging and refining information, bargaining, moving toward closure, reaching and overcoming impasse and obtaining settlement agreement. Effective negotiation incorporates comparative analysis, contingencies, interests and options. Options that are unrealistic or outside the parameters of reason, may lead to decompensation, failure or a dismantling of a negotiation.

The human relationships that exist, including in the medical setting, encompass those issues and complexities integral to human interactions, such as integrity, identity, trust, fear, happiness, conflict, respect, and acceptance, among many others. Relational ethics emphasize mutual respectful relationships in which people work diligently to improve their awareness and their choices with actions that help to shape their conversations and social interactions [9]. As with all human interaction needing conflict resolution, the clinician (as master negotiator) must prepare and set goals, initiate conversation and be fully and whole heartedly committed to the interactions, and conduct a thorough and thoughtful (verbal and nonverbal) exchange. The clinician must also be a participant in bi-directional refinement of information and be able to bargain medical care (always with consideration for medico-legal standard practices), move toward closure, overcome impasse or resistance and achieve a settlement arrangement, i.e., appropriate plan of acceptable care. *"You have a number of signs and symptoms; headache, fever, malaise, and blurry vision, so I would like to go through a listing of possible diagnoses and discuss how we can sort through each one of them to figure out what is going on. Does that sound reasonable to you?"*

As the process unfolds, the negotiator attempts to problem solve by summarizing the party's conflict narratives and outlining common ground. The negotiator asks open-ended questions, defines the issues, discusses interests, identifies miscommunications and incorrect assumptions, brainstorms possible solutions, negotiates and strategizes, to get beyond impasse and "close the deal." Negotiating is best accomplished by discouraging offensive offers and normalizing the "dance." Feelings are encouraged, communications must be confidential, and tactics are pursued for interest-related issues that impact the health and welfare of the individual. *"You look troubled, or may be you are having some concerns about the tests and evaluation strategies. Please let me know how I can clarify or get a better understanding of your concerns."*

In a medical setting with patient/family and clinician interactions, the relationship may be filled with frictional

conversation, differences of opinions, emotional versus rational understanding and/or speaking, conflict(s) at multiple levels, interest discontinuity, fear, nervousness, and ambivalence. Any of these, along with insufficient disease/injury specific knowledge, may impact and lessen the possibility of concessionary behavior. Invariably and realistically, any relationship that focuses on the intra- and interpersonal skills that constitute all human relationships must account for differences and the outcomes associated with them.

In the clinical setting, the complexities of disease specific information, communication, emotion, resistance, perception of life, (and death), disability, socio-demographics, religion and personal beliefs, all intersect and collide to make the negotiation and acceptance of medical care challenging, and obstacle-ridden. No over-simplified scheme or model can provide a "prescription" to follow, regarding how best to configure the component parts of patient/family and clinician interaction in all clinical scenarios, or in all medical settings that will ultimately lead to uniform acceptance. Therefore, a well thought-out and collaborative process honors the fact that conflict exists. *"I know you have talked to the other people and have gotten ideas regarding the best treatment strategy. I also know that your ideas, culture and background help you to determine the best treatment path, going forward. Please explain, so I can understand and be sensitive to your needs."* A process must be in place that is workable, goal-directed, teachable, enforceable, and embraced by healthcare collaborators. Even, the Joint Commission emphasizes the need for conflict management in order to improve quality of care and protect patient's safety [10].

As the process begins to take shape and develop, the medical encounter should appropriately convene with the clinician opening the session in an organized, thoughtful, sensitive, and in an interest (rather than position) driven manner. As bargaining proceeds, a predetermined and well-conceived plan can be initiated, maintaining flexibility as the session continues. Among many possible applicable models, one published by Rahim, called the Dual Concerns Model suggests that there is a strategy which takes into account the intersection of 2 frank questions: how much concern do I have in achieving my desired outcomes in the negotiation; and how much concern do I have for the current and future quality of the relationship with other parties [11]. By extrapolation, this model suggests that when there is a high concern for the relationship and a high concern for the outcome, the approach can be collaborative.

Similar in result to the high values placed on relationship building and outcomes, as in the Dual Concerns Model, the facilitative approach which incorporates distributive and integrative interest negotiation strategies and tactics appears to involve the best concessions and reciprocity in a therapeutic relationship. This approach allows for compromise and collaboration, helps to build trust and empathy, identifies issues and interests by asking appropriate diagnostic questions, validates each party's perspective, lessens a more authoritative approach, helps to generate ideas regarding care

and treatment, and uses concessions and/or reciprocity in order to achieve agreement. *"In the past, I know that your physician has been very direct telling you what needs to be done, but in my experience, I hope to create some openness, sensitivity and dialogue so that I can better understand and work with you."* This shared value and culture leads to less competition, a greater commitment, a strengthening of communication channels, narrowing of the bargaining range, a more mutually perceived framing of the interaction, and greater interdependence on the common goals of the negotiation. In addition, it is likely that the intangible factors that impact decision making and the influence of the interaction aimed toward the common end-goal can be fortified.

Impasse occurs in a therapeutic setting whereby the patient/family and clinician are unable to compromise over care/issues. Strategies can be undertaken to overcome the obstacle such as asking appropriate diagnostic questions, assessing disease or injury knowledge, framing or reframing to shift perspectives on the issues, compromising on offers that makes sense to both parties, utilizing concessions and reciprocity to close the gap, performing a cost-benefit analysis or discussing the best alternative to a negotiated agreement with the patient/family and clinician. *"I can tell from our conversation that we are hitting an obstacle. I sincerely would like to understand what is causing that; is it that you need more information about the disease, or is it some other area that I can address?"* Another strategy may be to look at it from an emotional perspective, such as, *"can you please tell me your thoughts and feelings about our discussion so far, and what doesn't feel right to you?"*

The clinician must also fully embrace the concept of emotional and social intelligence, or "the skills that enable an individual to understand the impact of emotions on behavior and thinking in order to understand social interactions and engage in adaptive ways with others in social situations." [12]. Identifying specific skills and abilities related to emotional and social intelligence helps a clinician achieve goals and become more effective. Higher levels of emotional intelligence have been shown to correlate with the use of collaborative conflict style [13].

Developing an awareness among clinicians that leads to a healthy, compromising, and a negotiated settlement/agreement is not necessarily intuitive or simple. Insights must be gained from self-reflection; strategies must be preemptively organized, learned and patterned and negotiation must be taught, rehearsed and utilized. Patient/families will be satisfied, healthcare achievements will be seen differently, and collaboration will be seen as a true integrated partnership.

Understanding the nature of the concern or problem and having a goal-directed approach is paramount to settlement. In order to lower the friction and resolve the conflict, de-escalating strategies may be attempted: reassess verbal and nonverbal communication, speak in a supportive and empathetic way with matching tone, refocus the discussion on the patient/families interest(s), ask for communication clarification in order to determine possible misinterpretation,

provide medical information from multiple sources, and affirm with sensitivity and acknowledgement the struggles the patient/family may be facing, i.e., *"I can appreciate the difficulty in your situation. We are a partnership and ultimately, we are working together to create the best result for you. I will do everything to verify that you understand your signs and symptoms, your disease, what it will feel like..."* In addition, give definitive and convincing feedback on those medical issues already agreed upon and ask if alternative parties need to be involved who can offer support, such as friends, relatives, and clergy".

## Closing

The closing of the negotiation develops a final and agreed upon solution by all parties. Assuming that the recipe for bargaining was attempted and that the phases were carried out, but not to completion or agreement, a more assertive approach may be attempted to delve deeper into the obstacles in the interaction either misconstrued, misunderstood, maligned or misdirected.

If the negotiation was successful, the clinician must verify complete understanding of the agreement, outline and reaffirm the strategy and goals for current and ongoing care, when the next appointment should be made, plans for problems if they arise, what might be considered an "emergency," what to do in that instance, and how best to contact the clinician should problems occur. A confident handshake, smile and acknowledgement of the partnership should always be incorporated in the "goodbye" at the end of the encounter. *"I have truly appreciated the opportunity to work with you. We have gone over a significant amount of information today, and I want to make sure that you fully understand. Of course, we can spend some more time to clear up any thoughts, difficulties, or misunderstandings."*

## Summary

In summary, negotiating in a medical context can be challenging. This article should be construed as "food for thought" and an "enticement" when carrying out negotiations between patient/parent and caregiver. It is the obligation of the clinician to provide a healthy environment in order to come to consensus regarding care. This agreement can come about by thoroughly engaging in the stages as outlined above (convening, opening, communication, negotiation and closing) and embarking on the prescribed steps of negotiation; preparation and setting goals, initiation of interactions, exchanging and refining information, bargaining, moving toward closure, reaching and overcoming impasse and creating agreement. Clinicians must forge the barriers of malcontent; the risks associated with dissatisfaction, and be at the forefront in changing medical care as individuals and for healthcare in general.

## References

1. <https://macyinitiative.med.nyu.edu>

2. Plsek PE. Conflict engagement: Workplace Dynamics, Part 2: Appendix B: redesigning healthcare with insights from the science of complex adaptive systems. In: Committee on Quality of Health Care in America, Institute of Medicine, ed. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press; 2001. p. 309-322.
3. Lipsitz LA (2012) Understanding health care as a complex system: the foundation for unintended consequences. *JAMA* 308: 234-244.
4. Botelho RJ (1992 ) A negotiation model for the doctor-patient relationship. *Fam Pract* 9: 210-218.
5. Furlong G (2005) *The Triangle of Satisfaction: The conflict resolution toolbox*. Canada: Wiley, NY, USA.
6. Riskin L (1996) "Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed" 1 *HarvNegot L. Rev* 7.
7. Wright D, Brajtman S (2011) Relational and embodied knowing: nursing ethics within interprofessional team. *Nurs Ethics* 18: 20-30.
8. Helming MB, Jones M, Bartlett MA(2013) "Relationships: Therapeutic relationships in holistic nursing." In: Dossey BM, et al.(Editors). *Holistic nursing: A handbook for practice*. (6th edn)Burlington, USA, p.439-462.
9. Haslebro G, Haslebro MJ (2012) *Practicing relational ethics in organizations* (Taos Tempo series: collaborative practices for changing times). Chagrin Falls, OH: Taos Institute Publications, USA.
10. Joint Commission (2011) *Comprehensive accreditation manual for hospitals*. Oakbrook, IL: Joint Commission Resources.
11. Rahim MA (2002) Toward a theory of managing organizational conflict. *Int J Conflict Manag* 13: 206-235.
12. Siegel DJ (2012) *Pocket guide to interpersonal neurobiology: An integrative handbook of the mind*. New York: W.W. Norton and Company, USA.
13. Morisson J (2008) The relationship between emotional intelligence competencies and preferred conflict-handling styles. *JNursManag* 16: 974-983.