Negotiation: The CMO's Indispensable Skill

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IN THIS ARTICLE...

Negotiation is the most important tool that a chief medical officer, or any physician leader, can possess. Here are some tips and insights on ways to improve your negotiation skills.

You are the chief medical officer (CMO)—or almost any other senior medical administrator—at a 350-bed tertiary care hospital. A cardiologist insists on talking to you, right now, about "an urgent quality problem." A particular primary care physician, he says, who is in fact credentialed to read EKGs, is incompetent.

The latest instance supposedly led to unnecessary morbidity. The cardiologist demands that only cardiologists be credentialed to read EKGs, or that they over-read all primary care interpretations, and are paid by the hospital for doing so.

This isn't new. Five years ago the argument over who should read EKGs was "resolved" by new credentialing criteria and a new quality improvement committee (QI) composed jointly of cardiology and primary care.

The cardiologist says the QI committee has done nothing, and that if the issue is not resolved his way he will take it to the medical executive committee (MEC) or to the board of directors.

You know the board is the wrong place—this is a medical staff problem. While the MEC may be the right venue, this should not be an either/or choice. The divisiveness would just repeat the history.

You believe you have the authority to just decide it—after all, you're a "leader"—but you also know that leadership means having people agree, not just obey; and you suspect that others might think this belongs in their court, not yours.

It turns out this is not an isolated complaint. QI has reviewed multiple cardiology complaints, but has never found any convincing outliers (and this case is no different.)

That doesn't mean there isn't a problem. The cardiologists have been "chart-jousting." In retaliation the primary care providers have begun to make referrals off-campus; and the divisiveness has eroded communication to the point where patient care could be compromised. These look like symptoms of a dangerous problem.

In all, you prefer that the primary care providers and the cardiologists work it out, and you will facilitate the process.

Negotiation begins

Life is full of such problems. To solve these issues requires negotiation. The object is a durable solution that requires at least minimal buy-in by all of the stakeholders. The principles for getting there are few in number, but significant.

First is the distinction between "positions" and "interests." Positions are what people demand—like the cardiologist who insists on having primary care providers' privileges effectively reduced. Primary care has an opposite position. Positions in a dispute are usually incompatible.

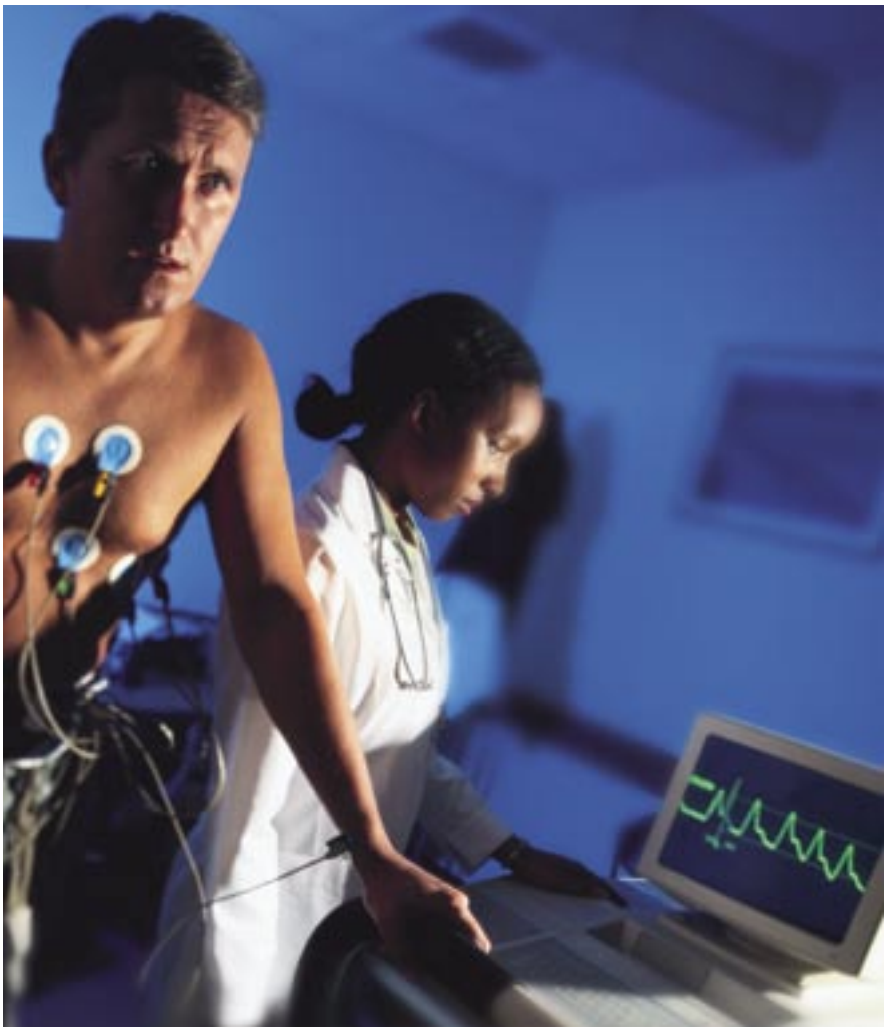
If positions are means, "interests" are goals. Cardiology's interest is what it really wants or needs. The distinction is important because, while positions are typically incompatible, interests might not be.

To illustrate with another example: a doctor insists that nurses chart something in a way that nurses, for equally good reasons, find impossible. Their positions—"You'll chart this way;" "No, we'll chart that way"—are incompatible. Their goals of effective communication about patient events are the same.

The key is to know what the underlying interests are, and then work to develop a solution that either aligns them or satisfies them simultaneously.

Second, no matter how destructive it may seem, everything everyone does serves some interest they believe they have.

Problem ripe for negotiation: The cardiologist demands that only cardiologists be credentialed to read EKGs, or that they over-read all primary care interpretations. The primary care providers retaliate.



The cardiologist is risking disruption of medical staff stability. But disruption is not (necessarily) his goal, which may indeed be a concern for quality of care. Or it might be a positioning of cardiologists vis-à-vis primary care, or the ethos of specialization itself.

Likewise, for the primary care physicians, the motivation may be continuity of patient care, for both quality and professional reasons. Sometimes the conflict could be about money, but it would be as dangerous to jump to the conclusion that anyone's primary concern is money as it would be to presume anything else.

The point of all of this is not only that resolution of disputes requires attention to real interests, but that durable resolutions—like the cure of disease— require attention to etiology, not just to symptoms.

Third, problems have owners—sometimes referred to as stakeholders—and owners have audiences. This problem's owners include cardiology and primary care. The hospital's administration might also want in.

These stakeholders in turn each have their own audiences—people or groups whose opinions the stakeholders care about. For a CEO that might be the trustees; for cardiologists it might be other specialists; for PCPs it might be other primary care physicians.

You might decide to have these others at the table. But even if they aren't, you have to understand who else is in the audience.

Win-win?

Primary care providers and cardiologists are intelligent, educated people. Why can't they work this out themselves? Because people who see themselves in competition (a mindset trained into the medical profession) sometimes get stuck for a number of predictable reasons.

Negotiation mavens use the phrases "win-lose" and "win-win." Win-lose means, I have to lose whatever you get and vice-versa: if primary care providers could not read EKGs, they would lose

whatever cardiologists would gain. Win-win is an arrangement in which both are better off. Reaching a win-win solution is too often blocked by people presuming, when it isn't necessarily true, that what's at stake must be win-lose.

Related to that is another shibboleth—that people won't negotiate when they don't think they have to. If the primary care providers can keep what they already have just by holding firm, why should they negotiate with anybody? This is a short-run attitude. The relationships that matter in a hospital are almost all long-term. But it happens.

More perniciously, sometimes people can't see a problem from any point of view other than their own. In negotiation, to have someone cooperate in solving your problem you have to help solve theirs. That in turn requires understanding what their problem is, as they understand it.

If what the cardiologists see is only the preservation of professional status, and don't see the primary care provider's concern with continuity of care, this is going to be a win-lose tug-of-war.

Exacerbating this is extensive diversity among professional cultures. Physicians think differently than nurses, and they both think differently than administrators. Proceduralists have cultures different from those of cognitive physicians.

Culture is language, ways of doing things and assumptions about what's right and what's wrong. When negotiation gurus talk about the challenges of cross-cultural problem-solving, they could well be describing the Babel of a modern hospital.

Overcoming these barriers to effective problem-solving takes knowledge and skill. Physicians solve medical problems every day, but are not trained to solve relational or even institutional problems.

That is not to say that relational problem-solving is something amateurs shouldn't try. It is to say that in the fast-paced and stressful environment of patient care, it takes precious time and conscious effort to think about how the blockages we've just described can be avoided or overcome.

Unblocked communication

The first objective of this negotiation, once you identify and engage the stakeholders, is to re-establish the communication that has been blocked by what we've just discussed—the win-lose assumption, the inconvertibility of differing cultures, and some people's singular definition of the problem.

But why is this mess on your desk? Because CMOs belong to two tribes at once: you're a physician, experienced as a medical professional, and you're a senior member of the hospital administration. You are fluent in both languages and you can do simultaneous translation.

You knew when you took the job that the hospital executives would look to you to guide the medical staff in the direction they want the hospital to go; that it would be you who would be principally responsible for the quality of care, the outside world's assessment of it, and its cost and efficiency.

As part and parcel of those jobs, it would be you who makes the service delivery work. Conflicts like this one, with cardiology and primary care unable to resolve their differences themselves, are challenges to all of those tasks. That's why this is on your desk.

In our view, the focus of your effort now is to align the contending interests within the medical staff not only with each other, but with the interests of the hospital administration and with the dictates of the highest attainable quality of patient care.

We also believe that how you do it matters— the ethics and values you personally represent create the culture and the ethics within which others are expected to work.

Resolving conflict may have value for its own sake, but the proper strategy in our view is not to address conflict, like the fracas today between the primary care providers and cardiology, as if its resolution were the only goal.

For one thing, most health care disputes are symptoms of more complex or more enduring problems percolating beneath the surface. For another, whatever the resolution of this one problem might be, it has to serve the wider institutional, professional and social goals that characterize the hospital.

Solving a conflict between two medical professionals in a way that makes them happy but leaves patients at risk is simply the wrong way to go. You, the CMO, are a major repository of those broader values.

In a way, then, you are not just a referee in a negotiation even though you are its principal manager. You are a party to the negotiation with your own audiences in the CEO and the medical staff, and with your own ends in mind.

Moreover, your goals must be transparent. At the same time, you are an asset yourself and cannot allow your personal capital to be wasted on things that don't matter, or to be consumed in the process of resolving those that do. It isn't easy. But it's essential. And it's your job.

Negotiation points

What mediators or facilitators do to achieve effective—and appropriate— resolution of problems like this one between the cardiologists and primary care include these key concepts:

Assure communication.

People make assumptions about each other, and especially about their adversaries. What they hear is often what they expect to hear, not what the other side is actually try-

ing to say. One tactic a facilitator might use effectively is to ask the cardiologist, in the presence of a primary care provider, what is it the cardiologist thinks primary care is saying. And vice versa. You might be surprised at the gap between perception and reality. Assuring real communication is the first step.

Build relationships.

Conflicts often take on a life of their own. A wound left unsutured can fester, and the sequel can be even wider infection. "Deals" don't work well without a substrate of trust. Effecting communication is again the first step. Structuring ways for communication to continue by building relationships is the second.

Get people off positions.

We have already talked about the difference between positions and interests. When people are at odds, they come to see their positions as if they were their interests—mistaking the means for the ends. Separately and privately, the facilitator can help each of the parties to the problem understand the difference, and see more clearly what their own best interests—and the interests they have in common with their opponents—actually are. Again, positions are usually incompatible; interests aren't.

Facilitate effective negotiation.

Good mediators understand that setting a table is an art, by which we mean that process management matters. That means assuring professional and appropriate tones, maintaining engagement, acting as "conversational traffic cop" to keep the process flowing and to avoid collisions, and helping to overcome the reluctance (at best) or intimidation (at worst) that can come with differences in professional status. It is also useful, especially in such cases, to make it both apparent and real that someone in a position of authority is listening, understanding and assuring safety for everyone in the conversation.

Do reality training.

A frequent blockage to successful resolution is a belief by at least one of the parties that they don't have to negotiate—that the circumstances are such that they can keep all the marbles even if they never sit down to talk about it. That is seldom the case, but rationalization is a common human trait. A credible neutral can help people assess their alternatives more realistically.

Bring workable new ideas.

Once everyone understands everyone else's needs, limits and concerns, the focus turns to developing solutions that have two characteristics. One is to satisfy as much as possible each side's needs at a cost acceptable to the other. The other is to achieve win-win outcomes that are appropriate not only for the immediate contenders, but for the hospital and the mission they have in common.

Sometimes "brainstorming" works—fostering the freedom to suggest ideas without restraint. The best ideas are those that come from the parties themselves, since they then see themselves as the authors and the owners of the solution. Sometimes, however, they get stuck—they may not have a big enough picture to be able to see comprehensive solutions, or they may have incorrect assessments of what's actually possible. CMOs do have the big picture. And they usually have a good sense of what's real. Just one caution here: vet your own ideas with each side separately before blurting them out in the presence of all. You could create an awkward situation that would be counterproductive.

Bring in an outside mediator.

Even good inside facilitators should sometimes engage an independent mediator. The local history, for example, might bring someone to question the CMO's ability to be neutral, or to suspect an undisclosed agenda. Or the stakes—and the probability of success—might be such that a CMO needs to preserve his or her own political capital. Moreover, an experienced outsider would not be limited by the insider's frame of reference.

Back now to the cardiologist, the primary care providers and the EKGs. You've learned the background, identified the stakeholders and their audiences, articulated for yourself what the larger implications are for both success and failure, you've brought everyone together, and you've set the table.

Everyone looks at you to start the meeting and do it right. Good luck!

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