Second Edition

Organizational Behavior in Health Care

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Conflict Negotiation Models

Rubin and Brown (1975) define negotiation as the process by which two or more parties decide what each will give and take in an exchange. Since the 1960s, there has been extensive research in the field of conflict resolution or conflict management. From this research, three major negotiation models have been developed: (1) distributive, (2) integrative, and (3) interactive. Each of these models is associated with different goals and indicators of success, and each may be most appropriately applied in different contexts (Winder, 2003).

Distributive Model

The distributive model originated within the field of labor negotiations (Lewicki et al., 1992; Stevens, 1963; Walton & McKersie, 1965) and can be described as a set of behaviors for dividing scarce resources. Distributive negotiation is often referred to as "hard-bargaining" or a win–lose, zero-sum approach. The negotiators are viewed as adversaries who reach agreement through a series of concessions with the goal of obtaining the greater "piece of the pie." Tactics used in the distributive negotiation model are withholding information, guarded communications, power positioning, limited expressions of trust, use of threats, and distorted statements and demands (Walton & McKersie, 1965). Brett and Shapiro (1998) referred to distributive negotiations as a tug-of-war game with each party trying to tug the other to its own side. The winner wins when the opponent's strength gives out and the opponent is pulled across the midline. The result is a one-sided agreement, where resolved issues favor one side more than the other.

Winder (2003) outlines the four win–lose strategies practiced by negotiators using the distributive approach. The first negotiating strategy is the "I want it all" tactic. This tactic involves making extreme offers and then granting concessions grudgingly, if at all. One party hopes to wear down the resolve of the other by pressuring the other to make significant concessions and forcing the other party into a position of nonreciprocation. The second negotiating strategy is "time warp." The time-warp tactic communicates an arbitrary deadline for acceptance of the offer. For example, the negotiators will relate to the other party that an offer is only good until a certain date and time. If not accepted by the arbitrarily set deadline, the offer will be withdrawn. The third negotiating strategy is the "good cop, bad cop" scenario. In this scenario, one party attempts to sway the negotiator by alternating sympathetic with threatening behavior. The fourth negotiating strategy is the "ultimatum" tactic, which is designed to try to force one party to submit to the will of the other. In this negotiation approach "take it or leave it" offers are presented, and one party overtly tries to force acceptance of demands—one party is unwilling to make any concessions, and the other party is expected to make all of the concessions (Fisher, Ury, & Patton, 1991).

Integrative Model

The integrative negotiation model, similar to the distributive model, evolved primarily within the field of labor negotiations (Follett, 1940, 1942; Lewicki et al., 1992; Walton & McKersie, 1965). It is currently one of the most

frequently used models of conflict resolution because of its collaborative versus confrontational approach.

Integrative negotiation is a cooperative, interest-based, agreement-oriented approach to dealing with conflict that is viewed as a "win–win" or mutual-gain dispute. Integrative negotiation is a process by which parties attempt to explore options to achieve mutual gains versus unilateral gains. Parties recognize and define a problem, search for possible solutions to it, evaluate the solutions, and select one that maximizes joint gains (Lewicki et al., 1992).

Filley (1975), building on the work of Walton and McKersie (1965), developed an integrative decision-making model. Filley's six-step approach is as follows:

1. Create an environment that promotes equality, cooperation, communication, and information sharing
2. Review and adjust perceptions
3. Review and adjust attitudes (i.e., create processes that maximize information-sharing and "clear the air" of past hostilities and negative attitudes)
4. Define the problem
5. Search for alternatives
6. Achieve consensus

The concept of integrative negotiation is based on a value system that stresses interpersonal trust, cooperation, a willingness to share information combined with open communication, and a search for mutually acceptable outcomes (Lewicki et al., 1992). This model looks beyond the existing resources and aims to expand the alternatives and increase the available payoffs to both parties through joint problem solving (Winder, 2003).

Fisher and Ury (1981) and Fisher et al. (1991) define integrative negotiation as "principled negotiation." The researchers suggest that negotiations should be grounded in substantive concerns when the participants:

- Separate the people from the problem. In other words, separate the issues in conflict from the personal relationships. Negotiators should be hard on the issues, but do so in a cooperative relationship with the other party.
- Focus on interest or need rather than position. In other words, do not allow individual egos to negate the negotiation process. This requires trust, respect, and open communication by both parties.
- Identify best alternative to a negotiated agreement (BATNA) for both parties. By identifying BATNAs, the parties' goal will be to achieve better outcomes than their BATNA through negotiations.
- Invent options or alternatives that provide mutual gain. Brainstorming, prior to and during meetings, will assist in developing creative alternatives.
- Insist on using only objective criteria to judge solutions. When negotiations are based on objective versus subjective criteria, discussions focus on equitable solutions, not false assumptions.

The integrative-conflict model encourages equitable solutions to problems. Negotiators are viewed as partners who cooperate in searching for a fair

agreement that meets the interest of both sides and seeks to maximize the gain for all the parties involved (Winder, 2003) (see "Creating a Win–Win Situation" in Case Study 14–4).

Case Study 14–4 Creating a Win–Win Situation

A hospital anesthesiology department is deeply financially troubled. Department leaders approach senior hospital administrators seeking additional funds. Department leaders say without funding they will lose staff and be forced to close operating rooms. The administrators take the position that if they provide funding to the anesthesiology department, every department will demand it. Furthermore, the anesthesiology department has enjoyed the privilege of having an exclusive contract. If rooms are closed, the hospital may entertain looking at other anesthesiology practices. The senior vice president for medical affairs (i.e., VPMA) is called in to mediate. A meeting is set up to negotiate a solution.

Applying Fisher's principled negotiations, how should the VPMA proceed?

The first component of principled negotiation is to attack the problem over which the parties are negotiating. The further apart the positions, the more likely emotions will obscure the objective merits of the problem. Most negotiations are as much about emotion as they are money. The negotiation process will deteriorate rapidly if both sides firmly settle into their respective positions. If the anesthesiology group and hospital administration settle into their respective positions of closing rooms and denying the anesthesia group their exclusive contract, the negotiation soon will become a series of personal attacks.

The first step is for the VPMA to acknowledge that negotiation is an emotional undertaking. As mediator, he or she should encourage both parties to consider what they would be thinking if they were on the other side of the table. The point is to get both parties to address the problem and not to react immediately to emotional outbursts.

Relationship building and the "spirit of the deal" are important factors to keep in mind. The way to accomplish this relationship building is simple. Lay down the ground rules so that each party agrees to show the same degree of honesty, respect, and fairness that it would demand from others.

The ultimate objective of any negotiation is to satisfy the underlying interests of each side in the best way possible. As mediator, the VPMA must get each party to recognize the importance of each other's interests.

What are the interests of each group in this example? For the anesthesiologists, it may be increasing salaries to retain current staff and recruit new staff, while not having to work unreasonable or unsafe amounts of time to achieve this goal. For the hospital, it may be maintaining or even increasing operating room time to retain and attract high-volume surgeons.

The point is that each side has multiple interests. Positions such as "We will close down an operating room" obscure the underlying interests. Both parties must be cautioned to recognize and avoid any preconceived perceptions they may have about the other party.

For example, not all anesthesiology groups seeking stipends are greedy. Not all hospital administrators are clueless to clinical issues. No attempt should be made to discard any solutions until there has been a discussion of the problem and interests at hand.

With the interests articulated and understood, the VPMA should begin to look at options, looking first for shared or common interests. In this example, it is a common interest for both the anesthesiology group and hospital to keep the operating rooms open and running, since both derive revenue from the cases (i.e., common ground).

Unfortunately, it may be difficult or impossible to find common ground in many situations. As a result, capitalizing on differences may hold the key to developing options for achieving agreement. For example, the hospital may state that in order to provide a stipend, the anesthesiology group must be willing to expand operating room coverage in the evenings. The anesthesiology group may claim it does not have the staff to expand coverage and there is no need for expansion.

Could there be a solution in the disagreement? If both sides agree to look at both decreasing room turnover time and more accurate posting of procedure times by surgeons on the basis of his-

torical data, the interest of the hospital in providing time for high-volume surgeons, and the anesthesiologists' interest in not expanding evening coverage, might be achieved. Remember that agreement often can be based on disagreement.

Once the parties begin looking at options, the problem can be discussed on the basis of objective criteria. The VPMA must have both parties prepare objective data to present prior to negotiating a solution. The anesthesiology group should be prepared to have benchmarks as to current salaries, workload, and operating room staffing models. The hospital should know how other institutions handle stipends, the legal implications, and objective criteria used to judge performance.

SOURCE: "The role of the physician executive in negotiation," by D. P. Tarantino, 2004. *Physician Executive, 30*(5), pp. 71–73. Reprinted with permission.

Interactive Model

When negotiations become locked into a win–lose situation, a third party may be invited to assist in resolving the issues (Schwarz, 1994). Interactive problem solving is a form of third-party consultation or informal mediation. Third-party facilitators can be mediators, arbitrators, or consultants. Depending on the situation, a third-party facilitator may have high or low control of either the conflict-resolution process and/or the outcomes. For example, the third party in intraorganizational conflicts is most often the person in the hierarchy to whom the contesting parties report (Lewicki et al., 1992). In this situation, the mediator/supervisor would have high control of both the conflict-resolution process and the outcomes. Mediators usually have high control of the conflict-resolution process and low control of the outcomes (as demonstrated by the VPMA in Case Study 14–4); whereas, arbitrators have a low control of the conflict-resolution process and high control of the outcomes.

In general, interactive negotiation is designed to facilitate a deeper analysis of the problems and issues forcing the conflict. According to Winder (2003), interactive negotiation usually begins with an analysis of the needs of each of the parties and a discussion of the constraints faced by each side that make it difficult to reach a mutually beneficial solution to the conflict. After the analytical dialogue, the parties engage in joint problem solving versus a fight to be won. Interactive negotiation is less focused on directly helping parties reach binding agreements (excluding arbitration) and is more devoted to improving the process of communication, increasing perspectives and understanding, enabling the parties to reframe their substantive goals and priorities, and engaging in more creative problem solving. Other goals include improving the openness and accuracy of communication, improving intergroup expectancies and attitudes, reducing misperceptions and destructive patterns of interaction, inducing mutual positive motivations for creative problem solving, and ultimately, building a sustainable working relationship between the parties (Winder, 2003).

Managers need to understand and appreciate that negotiation is not a zero-sum game. Managers who demonstrate effective conflict-resolution skills are often seen as competent, effective leaders (Gross & Guerrero, 2000; Stamato, 2004). A study by Eckerd College's Management Development Institute (2003) found a significant link between a person's ability to resolve conflict effectively and his or her perceived effectiveness as a leader and suitability for promotion.

The sample for the study consisted of 172 employees (90 male, 82 female) from five different types of organizations. Approximately one-half of the participants were middle-level managers or higher in their organization; all of them participated in a program focusing on workplace conflict. The study revealed a strong correlation between certain conflict-resolution behaviors and perceived effectiveness as a leader and promotion potential. Employees who were perceived as good at creating solutions, expressing emotions, and reaching out were considered more effective. Destructive behaviors, on the other hand, such as winning at all costs, displaying anger, demeaning others, and retaliating were found to be the worst career advancement and leadership behaviors. Avoidance behaviors were found to be particularly problematic for would-be negotiators because individuals who are uncomfortable with negotiating, or perceive themselves to be unskilled or ineffective in negotiating, often avoid conflict and thus fail to manage differences effectively. Of particular significance is the study's finding that negotiation skills are an important aspect of leadership.

SUMMARY

In this chapter, we have seen that conflict can have both positive and negative outcomes, and that conflicts originate from a variety of sources. Conflict-handling behavior can be learned and managers should adapt their behavior to the situation to be resolved. Collaborative behavior is strongly desired as a way to manage conflict.

END-OF-CHAPTER DISCUSSION QUESTIONS

1. Explain the definition of conflict.
2. Describe the four basic types of conflict.
3. Discuss the five levels of conflict.
4. Describe the five conflict-handling modes.
5. Describe the three major negotiation models.

Case Study 14–5 What Went Wrong?

Tim Hardwood, CEO of Community Health System, hung up the phone with a heavy sigh. Tim had just received the news from Mary Martin, Vice President of Human Resources, that negotiations had stalled between the health system and the service employees' union. Mary related, "As of now, the 2000 service employees at our three hospitals are without a contract and threatening to strike. But don't worry, Tim. I told the union negotiators that the health system is prepared to handle a strike." "A strike, the media will have a field day with this!" Tim wondered, "What went wrong?"

Jim Brentward, one of the union negotiators, sat across the table from Mary Martin. Jim related that his members understood that the health system was having financial difficulties

because of the current state of the industry with decreasing reimbursements and increasing regulations, but the union members were not pleased with the health system's proposed offer for salary increases and benefit package over the next four years. He related that "unless the health system signed a contract by 5:00 PM Friday with acceptable salary and benefit increases, members of the union are threatening to strike." Jim continued, "The union plans to hold an informational picket on Thursday, and although the union doesn't want to strike, it's a strong possibility. After the informational picket, we will hold a strike vote and see what our members have to say about the situation."

Mary was shocked by Jim's comments. She simply could not believe that Community's service employees would threaten to strike! Because of her position as Vice President of Human Resources, Mary knew that the service employees represented by Jim's union were in the bottom-end of the health system's pay scale. These employees included patient transporters, housekeeping, and cafeteria workers. Mary also knew that union benefits paid during a strike represented only 50 percent of the employee's/member's weekly salary. Mary felt confident that because of financial restraints, the employees would never vote to strike; they had too much to lose. In addition, she knew that Community Health System was considering outsourcing its dietary departments to Thomson Healthcare Food Services. If the employees did strike, although Mary considered it very unlikely, that aspect of services would continue without interruption. Knowing this inside information, Mary decided she wasn't going to let Jim and the other union negotiators bully her. Mary responded by stating that the health system would not give in to the union's demands and it was prepared for a strike.

Explain to Tim Hardwood what went wrong. If you were hired as the mediator, how would you go about resolving the situation to achieve a win/win agreement?

Case Study 14–6 Healthy Conflict Resolution

"Cindy, please reschedule my afternoon clinic; I am going to be out for the rest of the day," says Dr. Jones, a senior physician in a hospital-owned multispecialty group.

"But, Dr. Jones," Cindy says while whipping off her telephone headset and turning away from the open patient registration window, "you are double booked for most of the afternoon because you cancelled your clinic twice this month already. Many of these patients have been waiting more than three months to see you!"

Jones glances furtively at the waiting room, and already half turned and heading toward the clinic exit says, "I'm sure you will be able to smooth things over. Just tell them that I got called to an emergency."

Cindy has a suspicion that, because the weather is nice, Jones is taking off with a couple of colleagues to go sailing or play a round of golf. After all, he always sports a darn tan, comes to clinic late, and often leaves early. Cindy does not relish having to call and reschedule these patients, some of whom have already been rescheduled at least once in the past couple of months.

Cindy decides enough is enough. She calls her manager and requests a meeting as soon as possible. Her manager can sense that Cindy is upset and offers to have someone cover for Cindy so that they can talk privately.

Cindy tells the manager about the situation with Jones that happens "all the time," and how she is "sick of it," and will not "work another day under these conditions." After calming Cindy down, the manager promises to bring the matter up with the chief of the department.

To make a long story shorter, suffice it to say that this conflict continues to mushroom to involve several more individuals (the chief medical officer, the executive director of the clinic, the director of HR, and the union representative) before Jones is ever made aware that Cindy has filed a formal complaint about him. When he is finally confronted, in a meeting with the chief medical officer and the director of HR, he is caught completely off guard.

After all, the incident happened several weeks ago, and Cindy did not mention anything to him about it. They have continued to work together, in his opinion, as if nothing is wrong. He is also surprised to find out that Cindy has been keeping a tally of the number of times that he has cancelled his clinic, left early, or started clinic late.

Jones goes from astonishment to red-faced anger in a few minutes. It is clear to all that the relationship between Cindy and the doctor is irreparable. Jones is labeled as a disruptive physician. Cindy is not welcome in any department because the other physicians are fearful of being targeted. Cindy eventually resigns, and Jones feels betrayed and unappreciated by his staff and his employer.

If you were the manager in this case, how would you have handled the situation?

SOURCE: Pierce, K. P. (2009, January/February). Healthy conflict resolution. *Physician Executive, 35*(1), 60–61.

Case Study 14–7 Conflict-Handling Styles

For each of the five scenarios described below, determine what is the most appropriate conflict-handling style(s).

Scenario One

A radiologist on the staff of a large community hospital was stopped after a staff meeting by a colleague in internal medicine. On Monday of the previous week, the internist referred an elderly man with chronic, productive cough for chest X-ray, with a clinical diagnosis of bronchitis. Thursday morning the internist received the radiologist's written X-ray report with a diagnosis of "probable bronchogenic carcinoma." The internist expressed his dismay that the radiologist had not called him much earlier with a verbal report. Visibly upset, the internist raised his voice, but did not use abusive language.

How should the radiologist handle this conflict with the internist?

Scenario Two

The Family and Community Medicine Division of a large-staff model HMO serves a population that is ethnically diverse. The senior management team of the HMO, spurred by repeated complaints from representatives of one racial group, has encouraged the division, all of whose physicians are white, to diversify. Several black and Hispanic physicians with strong credentials apply for the open positions, but none is hired. Weeks later, a young female family physician learns from several colleagues that the division director has identified her as racist and the obstructionist to recruiting. The comments attributed to her are not only false but are also typical of discriminatory statements that she has heard the division chief utter. The rumors about her "behavior" have circulated widely in the division.

How should the young female family physician handle this conflict with the division chief?

Scenario Three

A manager who reports to the Vice President for Clinical Affairs (VPCA) of a tertiary-care hospital hired a young woman to supervise development of a large community outreach program. During the first four months of her employment, several behavioral problems came to the VPCA's attention: (1) complaints from community physicians that the coordinator criticizes other physicians in public; (2) concerns from two community leaders that the coordinator is not truthful; and (3) written reports about the project that label and blame others, sometimes in language that is disrespectful. The VPCA spoke several times to the manager about these problems. The manager reported other dissatisfactions with the coordinator's performance, but he showed no sign of dealing with the behavior. Two more complaints come in, one from an influential community leader.

How should the VPCA handle this conflict with the manager?

Scenario Four

The medical school in an academic health center recently implemented a problem-based curriculum, dramatically reducing the number of lectures given and substituting small-group learning that focuses on actual patient cases. Both clinical and basic science faculty are feeling

stretched in their new roles. In the past, dental students took the basic course in microanatomy with medical students. The core lectures are still given but at different times that do not match with the dental-curriculum schedule. The anatomists insist that they don't have time to teach another course specifically for dental students. The dean has informed the chair of the Department of Anatomy and Cell Biology that some educational revenues will be redirected to the dental school if the faculty do not meet this need.

How should the dean handle this conflict with the chair of the Department of Anatomy and Cell Biology?

Scenario Five

The partners in a medical group practice are informed by the clinic manager that one physician member of the group has been repeatedly upcoding procedures for a specific diagnosis. This issue first came to light six months ago. At that time the partners met with him, clarified the Medicare guidelines, and outlined the threat to the practice for noncompliance. He argued with their view, but ultimately agreed to code appropriately. There were no infractions for several months, but now he has submitted several erroneous codes. One member of the office staff has asked whether Medicare would consider this behavior "fraudulent."

How should the partners handle the situation with the other physician partner?

SOURCE: "Managing low-to-mid intensity conflict in the health care setting," by C. A. Aschenbrener-Siders, 1999, *Physician Executive, 25*(5), pp. 44–50. Reprinted with permission.

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