Negotiation Skills for Medical Educators

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Medical education is expensive.[1] The expense is sometimes borne by learners and their families, sometimes by institutions, and sometimes by governments.[2] Graduate medical education is no different from other forms of medical education in terms of its expense. There is the cost of curriculum development and delivery for residents, the cost of resources (such as equipment, technology, or e-learning resources), the cost of assessment (be it formative or summative), and the cost of program evaluation.[3] In this article, *assessment* means assessing the learners, whereas *evaluation* means evaluating the course, curriculum, or program. Some of these costs are sunk costs; some are fixed costs. However, others are negotiable. For example, the costs of resources provided by the institution—like simulation equipment—are often negotiable. Institutional purchasers and commercial providers of such equipment can negotiate on price, amount, or a number of other variables. Commercial providers understand negotiation skills, and many of their staff will have been trained in these skills. Those responsible for the purchase, however, are less likely to have a commercial background, so they are less likely to have the skills necessary to ensure the best possible deal for their institution and learners. The purpose of this perspective is to introduce the topic of negotiation for those who are responsible for ensuring that their institution gets the best possible value for its purchases. Sometimes medical educators need to negotiate for space and/or time in the curriculum, and negotiation skills are needed in those circumstances as well.

Goals of Negotiation

Perhaps the first most important point to keep in mind when considering negotiating is that negotiation may have different purposes. The purpose might be to reach a genuine compromise, to agree on next steps, to get a bargain, to generate good will, to satisfy relevant stakeholders, or to achieve a number of these ends. The number of possible intended goals when negotiating is endless. However, it is always wise to keep the end in mind when beginning the process because that endpoint will inform the methods used to get there. There are a variety of methods that can be used in negotiation, yet most of these are subcategories of 2 broad strategies.

Strategy and Tactics

One strategy is positional negotiation.[4] In this strategy, both sides adopt a position—typically some distance from the position that they would ultimately be willing to compromise on. Then a slow process of incremental compromises begins until both sides reach a point that the other side is willing to accept. An example might be 2 departments that must compete for the same budget. Inevitably, there will be a fixed and limited budget, so one side's win will result in an equivalent loss for the other side. In a nonmonetary negotiation, the 2 departments may be negotiating about curricular time—although the same principles still apply.

Interest-based negotiation by contrast seeks to create value for both sides by means of the negotiation.[5] It requires both sides to see the problem from the other's perspective and consider how they could work with the other side to satisfy both their interests. For example, a medical education department might be able to negotiate a price reduction in simulation equipment by offering a free exhibition to the simulation provider at a regional medical education conference. The value of the free exhibition might be more than the discount offered. However, what is important to the purchaser is the discount, and what is important to the seller is the exhibition. In this way, both sides will have won. Once again, interest-based negotiation may be applied to noncommercial situations. For example, 2 departments might be competing for resources. Space might be more important to one department, and faculty to the other. If both sides are explicit about what they want, then they are more likely to be able to come to an agreement that will suit them both. In this article, I advocate heavily and explicitly for interest-based negotiation in medical education.

After strategy comes tactics. There are a wide variety of negotiation tactics. Broadly, they might be grouped as the tricks of the trade. However, in my opinion, medical education is not a trade or at least not a trade in which to be tricked. Decisions about medical education should be long term and strategic—short-term wins at the expense of another group will not result in long-term success. Negotiation tactics, however, are worth knowing—not so that you can use them yourself, but rather so that you will know when someone else tries to use them on you.

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BOX **The Language of Negotiation**

Think about the language you use in negotiation. Try to use language that is explicit and transparent and that will encourage reciprocity in others around the table. Here are 2 examples:

- "Thank you for being so straightforward about what you need. What our department needs is more space, so that we can have room for our faculty."
- "Curriculum time is limited, and neither of our departments has enough. Is there a way we could both win? Our department is respiratory medicine and yours is primary care—could we have a shared study module on respiratory symptoms in the community?"

Negotiation tactics most commonly involve brinkmanship, bluffing, creating artificial deadlines, playing "good guy/bad guy," or overwhelming the other negotiator with so much information that they don't know what is important and what is not. Many of these tactics are easy to spot—the best way to deal with them is to ignore them.

If these factors are "borderline" in terms of their use in negotiation, then other negotiation tactics are dishonest and should never be used. Indeed, if they are used by the other party, these are grounds for breaking off the negotiation. Dishonesty might involve telling active untruths to mislead the other party, but more commonly involve "bad faith" negotiation.[6] This usually means using negotiation as a delaying tactic, or as a means to show one is willing to compromise, when, in fact, one has no intention of compromising at all.

The use of tactics is based on the assumption that the negotiation taking place is positional negotiation—that one side will win and the other will lose, or that one side will win more than the other. Tactics are not essential in interest-based negotiation. Here, imagination is what is needed. Medical education is a deep and rich specialty in which there is more than sufficient room for negotiators to find grounds that are more valuable to one stakeholder than another, to be explicit about this, and to "give" on such grounds in the well-founded expectation that one will receive in return. Many fields in medical education have utility or value, and this value is typically made up of multiple components. Often, one component of utility can be balanced against another. By balancing and rebalancing, progress can be made in negotiation that will result in tangible benefits for both sides. Let's look at the following examples.

Simulation in medical education can be high cost or low cost, high fidelity or low fidelity, high technology or low technology, highly accessible or poorly accessible.[7] A number of different permutations emerge when these components are put together. For example, simulation can be high cost, high fidelity, and high technology, but poorly accessible. Alternatively, it could be low cost and low technology, and yet high fidelity and highly accessible. When purchasing simulation equipment, the buyer might map out these options with the provider and explore how value could be gained for both sides. For example, the buyer might value accessibility, fidelity, and cost for what they are trying to achieve in terms of learning outcomes; therefore, technology and the physical learning environment might be less important. At the same time, the seller might outline what he or she wishes to achieve—a substantial income in the short term and a satisfied and loyal customer whose needs have been met in the long term. To achieve accessibility, the purchaser might have to buy considerable volumes of equipment that are high fidelity, so the seller could offer a substantial discount because of the bulk purchase. Low-technology equipment might similarly result in lower costs. No one needs to worry about getting a state-of-the-art simulation suite because the physical environment is less important. In this way, both could achieve their goal. It is obvious that none of this could be achieved if either side is using tactics, playing games, or concealing their needs and desires. In summary, skillful, interest-based negotiation can save expenses in medical education and improve outcomes for a number of different parties. This example uses the purchasing of simulation equipment to demonstrate interest-based negotiation. However, the lessons learned can be extrapolated to a range of other areas, such as negotiating for faculty time, space, or resident participation (BOX).

Conclusions

As always, there is a single exception to the rule. The one tactic or skill that is often necessary is stamina. Negotiation can take time; it requires patience and sometimes a dogged determination to achieve the end result. At the start of a negotiation, multiple points of disagreement may make compromise seem impossible, but after a few hours of discussion, most people will be so eager to draw the negotiation to a close and make a deal that they will be far more likely to compromise at the end. Good stamina will mean you will be able to keep going right to the line.

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