"The way we see things is affected by what we know or what we believe."
-John Berger

Negotiation Skills Training: A Pilot Project

Introduction

The Nursing profession has made significant advances in alerting the public and nurses themselves of the value of nursing services. Recent studies have found that when nurses are valued, have appropriate resources to care for patients and have collaborative relations with physicians, patient care is improved and nurses are more satisfied with their practice. (Aiken, 1998, Aiken et. al., 2002, Needleman et. Al., 2002, Vahey et. al, 2004, Ives Erickson, et. al., 2002).

Nurses play a critical role in the U.S. health care system. They monitor patients' status, coordinate their care, educate them and their families, and provide essential therapeutic interventions. In fact, recent research documents that how well patients are cared for by nurses can be a matter of life or death, (Aiken, et al., 2002. Aiken, et. al.,1994 Institute of Medicine, (IOM, 2004), (Mitchell & Shortell, 1997).

Purpose

The purpose of this paper is to describe and evaluate the development and implementation of an educational intervention, entitled "Negotiation Skills for the Acute Care Staff Nurse". This two-hour session was incorporated into an already established workshop entitled: *Workforce Dynamics: Skills for Success*. The original workshop's purpose was to increase participants' understanding, knowledge and skill in the areas of: managing and working within a multigenerational culture, and preparing for and engaging effectively in difficult conversations. The added two-hour session, "Skilled Negotiation" was designed ***to assist nurses to understand the necessity for skilled negotiation, develop assessment skills to understand their personal style of negotiation, and to identify methods for assessing, evaluating and implementing negotiation skills.***

The overarching design feature of the session was the concept that conflict occurs in hospitals and that the hospital's culture and organizational structure are significant factors in understanding the need for negotiation skills. Information was introduced that allowed nurses to gain a better understanding of the organizational culture and structures in which they work. The goal was to provide nurses with insight so that they might understand and develop negotiation skills that would enhance their capacity to advocate for their patients and themselves. It was hypothesized that understanding the need for skilled negotiation would encourage nurses to improve their negotiation skills, and thus give them competencies to cope with these conflicts as they cared for patients.

It was expected that the nurses would realize that conflict was inherent in the everyday practice experience. The nurses would recognize opportunities to negotiate, improve their coping capacity and be more satisfied in their work. Ultimately, it was expected that these nurses would have better patient care outcomes. Of course a two-hour session can only begin to crack the surface of developing these strategies. However, this pilot was designed as a pilot for a longer term learning process at the patient care unit level.

The session was designed for nurses who practice in an urban academic medical environment. The environment is in these organizations is highly competitive. There is a constant struggle by clinicians for accessing scarce resources, i.e. time, money, equipment, space, and information for their patients. In addition, there is competition regarding status, roles, decision-making and academic privilege. Physicians are educated and socialized to thrive in this type of environment. Nurses are not.

Sources of Conflict

The environments in which nurses practice have many sources of conflict that impact the outcomes of patient care. These include: the recent history of organizational restructuring, the current nursing shortage and the most recent federal initiative to improve patient safety and the moral distress associated with it. If health care in the United States is to continue to develop and improve in quality, nurses must start to understand these factors, to believe in them and ultimately have the courage to address the issues.

Individual nurses face a great deal of conflict in their every day practice. These conflict situations involve other nurses, physicians, hospital administrators and ancillary health care providers and support personnel. In addition, patients and families who are hospitalized and facing a personal crisis create conflict situations require sophisticated interventions.

Many times the staff nurses at the bedside are the persons faced with the challenge of resolving conflicts to ensure excellence in patient care. This might be called “point of care” conflict. These conflicts emerge as the requirements of health care system collide with the needs of the individual patient. One communication competency that is helpful in managing conflict is the skill of negotiation. This competency, although not taught regularly has the potential to assist nurses cope with these conflict situations.

The Concept of Conflict

Historically, the concept of conflict was perceived as destructive. The early views of the organizational theorists to conflict management advocated suppression of conflict as necessary to organizational functioning, (Kolb, 1992). But an alternative view developed in the early 1970's, this view, suggested, that conflict was a phenomenon, which could have constructive or destructive effects depending upon its management, (Thomas, 1976)

This schema categorized conflict management into five distinct behavioral approaches: competing, compromising, collaborating, accommodating, and avoiding, (Thomas & Kilmann, 1974). In this framework, *competing* is an aggressive, uncompromising approach to conflict that is power-driven. The individual pursues his or her own personal goals without regard to others**.** *Compromising* is intermediate in both assertiveness and cooperativeness. Its approach focuses on quick, mutually agreeable decisions that partially satisfy both parties. *Collaborating* is both assertive and cooperative. It involves an attempt to work with the other person to find a solution that fully satisfies the concerns of both parties. *Accommodating* is characterized by cooperative, but unassertive behavior. The accommodating individual exhibits a self-sacrificing behavior by neglecting his or her concerns to satisfy the concerns of the other person. *Avoiding* is simply not addressing the conflict. It is an unassertive and an uncooperative response. This approach is used when the other party is more powerful and the cost of addressing the conflict is higher than the benefit of resolution. There is no chance of goal attainment; or time is needed to gain composure or more information. (Thomas, 1976)

In studies using this model, nurses repeatedly have reported that avoiding is their most frequently used strategy, indicating that decisions on crucial issues were not confronted but were arrived at by default. Accommodation and compromise were the next most used style. In contrast, the least often used styles were collaboration and competing, (Eason and Brown, 1999). The overuse of avoiding, accommodating and compromising are not in the best interests of the patients.

Additional research has further indicated that nurses tend to take a passive approach to conflict management, (Valentine, 2001). They tend to seek confirmation and support while also attempting to maintain harmony. Because of this fact, many nurses have developed ineffective responses to conflict, which leads to frustration, helplessness, and low self-esteem. (Douglass, 1996) Nurses often don't feel comfortable with learning about negotiation because to begin to negotiate may (and often is) perceived by others as nurses no longer being willing to protect harmony at the cost of their well being. (anecdotal information provided by Kritek…15 years experience)

And finally, nurses and other healthcare professionals are learning ways to promote their work-related interests through means such as negotiation, strikes, or integrative decision-making. Depending on how this conflict is managed, conflict can threaten the harmony

and balance of an organization or can be desirable and useful in improving organizational performance. (Douglass, 1996).

Nurses' overuse of avoidance as a conflict management strategy has the potential of creating the perception of powerlessness among nurses. In addition, this experienced powerlessness has the potential for developing quality of patient care problems. Lest one criticize nurses for their overuse of avoidance it must be recognized the people behave in ways that work for them. If you are a nurse working in an organization that does not allow conflict to be managed, it is difficult for that nurse to bring conflict to the forefront. It would require that all levels of the organization would be comfortable addressing issues that were "sacred cows". There is a realization on the part of the nurse that any movement to address the issue far exceeds the gains that can be actualized. There is a realization that it would be so distressing that one doesn't want to take it on. In addition, nurses like all humans learn by what they see modeled. If addressing conflict situations are not modeled well by administrative leadership, one can only expect physical and mental distress. Addressing conflict comes with a cost. That cost can ultimately end up being a fear of reprisal from the very administration that is recommending addressing the issues.

The Health Care Environments of Care and Organizational Restructuring

Over the last decade, the health care systems have undergone significant organizational change. Patient care and the roles of nurses and physicians have been redesigned and realigned to increase productivity and enhance efficiency. Over the past decade, changes in the economic environment of health care has reshaped the role of hospitals with the goal of reducing expenditure growth by restricting hospital use, shortening the patient's length of stay, and achieving greater efficiencies in inpatient settings with the goal of eliminating without adversely affecting patient care, (Aiken, et. Al., (1997), (Weinberg, 2003).

As a result, this organizational restructuring nurses have had to care for sicker patients, have had their roles expanded, been required to delegate more tasks to assistive personnel and have seen the introduction of increased documentation. The earlier expectations of the restructuring have not been achieved. There is absence of real progress toward restructuring health care systems that address both quality and cost concerns, or toward applying advances in information technology to improve administrative and clinical processes, (IOM, 2001), (Gerardi, 2004).

The unintended consequence of these restructuring efforts has been increased sources of conflicts in the hospital setting. The health care organizational environments has not adapted or evolved as quickly as the redesigned clinical and technological practices. Thus, the environments of care have become even more difficult and complex. The re-engineered organizations were left with poor communication, unclear policies, role confusion, turf battles and stressful interpersonal conflicts. (Baker et. al., 2003)

The nurse administrators, both nurse executives and nurse managers have spent most of their time projecting future practice needs, designing new organizational structures and ensuring that the limited resources were allocated appropriately to the demands of a problem-oriented, task driven patient care environments. (Picard & Jones, 2005). This focus has led to the neglect of educational resources necessary to ensure that staff nurses learned the communication skills necessary to manage the conflicts at the "point of care".

The Current Nursing Shortage

Not having enough nurses on the unit to care for patients is source of great conflict. Nursing shortages in the U.S. tend to be cyclical. However, this current shortage was preceded by a reduction in nursing staff across the country. From 1981 to 1993, the number of nursing caregivers at the bedside in hospitals declined by 7.3percent (controlling for the type and severity of patients' illnesses and the rise in volume of patients), even as all other categories of hospital staff increased. Reductions in nursing staff were more severe in states with high managed care penetration: the overall proportion of nursing personnel relative to inpatient volume and severity fell 27 percent in Massachusetts, 25 percent in New York, and 20 percent in California between 1981 and 1993. As a result, nursing personnel dropped from 45 percent of the hospital labor force in 981 to 37% of the hospital labor force in 1993, (Aiken, Sochalski, and Anderson, 1996)

But this current shortage portends an even greater shortage than in the previous cycles. (Buerhaus, 2003). Federal government analyses shows that there is a growing discrepancy between the supply and demand for registered nurses. This shortage is predicted to worsen in the near future, fueled by a projected 18 percent growth in the U.S. population between 2000 and 2020 and a 65 percent growth in the population over age 65. These demographic changes will require a disproportionately larger share of health care services. (Spetz and Given, 2003)

To worsen the problem, the largest cohort of nurses in the United States currently is aged 40 to 49, and there is a significant decline in the number of nurses who continue to work after age 50. With nurse labor market analyses indicating poor prospects for recruiting adequate numbers of nurses to meet US health care needs, retention of older nurses is imperative, (Aiken et al., 2002)

The recent public relations campaigns to attract young people into the nursing profession have been positive and there have been increased enrollment in the nation's nursing schools. However, there is not enough nursing faculty to teach them. According to the American Association of Colleges of Nurses over 15,000 qualified applicants were turned away in 2003 due to lack of faculty, clinical sites, classroom space, and/or budget (AACN, 2004) The impending crisis in nurse staffing has the potential to impact the very

health and security of our society if definitive steps are not taken to address its underlying causes.

Federal initiative to improve safety and moral distress

Another source of conflict is the burgeoning realization that adequate nurse staffing at the unit level is directly related to adverse patient outcomes, (IOM, 2001). The nurses who understand this relationship find themselves in an ethical dilemma. Alternatively, this research has led many healthy care administrators to recognize that nurse staffing affects quality of care, and thus they are reluctant to reduce staffing. However, if the staff is not available, these administrators must make decisions to close beds, thus depriving patients of needed care and the hospital of needed money.

According to Joint Commission data, staffing levels have been a factor in 24 % of the 1609 sentinel events, unanticipated events that result in death, injury or permanent loss of function. In a study conducted on behalf of the American Hospital Association, respondents reported that the nursing shortage has caused emergency department overcrowding in their hospitals (38%); diversion of emergency patients (25%); reduced number of staffed beds (23%); discontinuance of programs, (17%); and cancellation of elective surgeries (10%). In the wake of these and other reports health care organizations have rallied around the safety issue, introducing a variety of measures to reduce error, (Joint Commission, 2003)

The nurses' experiences have been confirmed by this information and it has created moral distress for nurses. In a survey of nurses describing their last shifts, 31 percent reported that their patients did not receive necessary skin care; 20 percent said patients did not receive oral care; and 28 percent were not able to provide patients and their families with necessary education and instruction. Shortage of ancillary personnel and other hospital workers have created a form of "scope creep" for the nurses' role. New tasks, supply chain management, housekeeping, food service and many other tasks pull nurses away from patient care and create conflict situations for the nurses.

Nurses are also overwhelmed with paperwork and administrative duties. A study commissioned by the American Hospital Association found that for every hour of patient care, 30- 60 minutes was spent on the subsequent paperwork.

In addition to the administrative and paperwork burdens that they bear, nurses are daily exposed to significant risks to their personal health and safety. Chronic fatigue, job-related injuries, including needle sticks, back injuries and physical assaults are common experiences on the job. In a recent study, by the American Nurses Association, more than 70 percent of surveyed nurses indicated that continuing severe stress and overwork were among their top health-related concerns. Forty percent of nurses reported having been injured on the job. (Joint Commission, 2003)

Organizational Culture and Structures

Organizational culture is the set of values, beliefs, and ways of thinking that is shared by ms of an organization. These values and beliefs create integrated patterns of human behavior. Culture is the unwritten, feeling part of the organization. Culture influences organizational learning and the transmission of knowledge to new employees. Everyone in an organization participates in culture, but culture generally goes unnoticed. (Daft, 1995). The culture itself impacts the way in which conflict is dealt with

Schein, (1985), describes six common meanings for organizational culture. They are observed behavioral regularities, norms, dominant values which are espoused by the organization, the philosophy which guides its practices, the rules of the game, and the feeling or climate that is conveyed in an organization. Leaders create organizational cultures. In fact, Schein, (1985) has suggested that the only of real importance that leaders do is to create and manage culture. It is the learned product of group experience.

Organizational structures constitute the specific ways that organizations are designed. And they too, impact the manner of conflict resolution. The structures represent the various dimensions of the organization. Examples of structural dimensions are hierarchy of authority, complexity of the work, who makes decisions, what standards are in place, the level of professionalism and the deployment of human resources. (Daft, 1995).

Organizational culture and structures are intimately related. The design of the organization is influenced by the individual behaviors in organizations and in the ways in which organizations structure themselves. (Katz & Kahn, 1978), (Schein, 1985). Becoming conscious of the relationship is a first step in preparing to learn negotiation skills. Understanding the context in which negotiations take place provides a new perspective. It is a lens through which negotiation skill can be taught.

Understanding the relationship between organizational culture and structures can help in understand how tensions among various parties mount and how each new conflict splits apart the parties involved. Unresolved conflict affects the various subgroups in which there is a great deal of dependence on one another to accomplish organizational goals. In the hospital environment the group that is most severely affected by this lack of understand is the patient and

Bureaucratic hospital structures

Historically, there are two major forms of organizational structures in use in the hospital; hierarchical or centralized control and the decentralized or participatory structure. Bureaucracy is the classic approach and is based on a hierarchical structure with legalized, formal authority embedded in the roles, and procedures. Common characteristics are (a) rules and regulations, (b) specialization of tasks and division of labor, (c) appointment by merit, and (d) an impersonal climate. (Douglas 1996). Most hospitals have some form of bureaucratic structures. In a highly bureaucratic structure there is less of a need to develop negotiation skills since many of the decision-making options have been placed in the rules, regulations and the specialization of tasks and division of labor.

There are four basic criticisms of the classic bureaucratic form of organization and management. (Douglas,1996). First, it neglects the human aspects of workers in the organization. Leaders in these organizations assume that the worker is motivated only by economic incentives. Also, the culture resists change and does not have structures that can respond quickly to the rapidly changing and uncertain environments. In addition, when the size of the organization is large, top managers become progressively out of touch with realities at the lower levels of the organization. Lastly, there may be a breakdown in communications between managers and subordinates, which permits counterproductive personal insecurities to develop. Bureaucratic cultures and structures hinder accomplishment of organizational goals in a rapidly changing environment. As

Participatory Structures

The second form of organizational structure is more participative and has emerged from the "human relations field" (Douglas, 1996). The human relations or participatory approach to management has shifted managers' attention from dealing solely on the organizational structures like roles or procedures and to making managers more sensitive to their employees needs. The basic principle of the human relations approach is that when things go well for the worker, the organization profits. Two factors are distinguishable in the human relations approach. First, certain leadership characteristics are associated with productivity and good management. Second, emphasis is placed on the worker, particularly as a member of a work group.

Hybrids: Shared or Collaborative Structures

Historically hospitals have developed within bureaucratic structures. But now, many are hybrids of both. Hospitals like other organizations have become less bureaucratic. Levels of hierarchy have become fewer and flatter, and job responsibilities and lines of report have become less formalized. Management styles have become less "top-down," less command-and-control". Nurses as employees, often find themselves with few hard-and-fast rules to follow about how things are done. (Babcock & Laschever, 2003). This change has created a need for increased negotiation skills. The environment is becoming more complex, decisions are being made a variety of organizational levels and rules, which were once embedded in regulations, are being made at the "point of care"

Hospitals over the past thirty-five years have experienced significant cultural and structural changes that include more participatory cultures and structures, which have a strong human relation focus. In the early 1980's, the American Academy of Nursing authorized a study to identify a national sample of what became known as "magnet hospitals" These hospitals were identified as those which attracted and retained professional nurses in their employment. The purpose of the study was to identify the factors that seemed to be associated with their success. This study identified and described the organizational variables that helped to create nursing practice and hospital environments that promoted the nursing staff's job satisfaction with accompanying fulfillment of both profession and personal needs. (American Academy of Nursing, 1983).

Since the designation of the original "Magnet Hospitals" by the American Academy of Nursing (AAN), magnet hospital status has been an important indicator of excellence in nursing care. One example of this type of hospital was a hospital in the Midwest. The nurses at this hospital documented their work in developing a professional practice model, shared governance structures, quality improvement systems and primary nursing. Their experience demonstrated excellence in patient care. (Pinkerton and Schroeder, 1988).

The revival of the magnet hospital designation by the American Nurses Credentialing Center (ANCC) in the early 1990's reemphasized the value for excellence at a time when nursing departments had become the focal point of controversies over patient safety, medical errors and labor shortages. The ANCC developed a demanding set of criteria to measure the strength and quality of hospitals and their nursing departments. Evaluating hospitals using these standards allowed the Center to identify hospitals where nurses delivered excellent patient outcomes, where nurses had a high level of job satisfaction, low staff nurse turnover rate and appropriate grievance resolution. In addition, in these hospitals, nurses were involved in data collection and decision-making in patient care delivery.

Magnet hospitals had nursing leaders who valued staff nurses, involved them in shaping research-based nursing practice, and encouraged and rewarded them for advancing in nursing practice. Hospitals were designated as Magnet when there was evidence of open communication among nurses and members of the health care team, and where there was an appropriate personnel mix to attain the highest patient outcomes and optimal staff work environment.

Magnet hospitals have a reputation for higher rates of retention of nurses and for excellence in nursing practice, and typically have few middle managers concerned with clinical decision-making. The nursing units generally operate autonomously, are self-governing, and participate in nurse-physician collaboration in department-wide issues that relate to them. Because the nursing staffs are educated, experienced, and clinically competent, they assume responsibility for patient care with the help of clinical specialists and a nurse
managerhttp://www.nursingadvocacy.org/research/shortage/magnet_hospital.html.

Why negotiation skills are necessary now more than ever

When the organizational culture and structures, Magnet Hospitals, encourage increased participation of nurses, negotiation skills become much more necessary. The environment of these hospitals changes dramatically. The bureaucratic rules become unwieldy and the need for negotiation competencies increases. Nurses in these organizations engage in numerous and varied interdependent relationships. For example, patients aware of their rights, wish to negotiate with doctors and nurses about their care. This new fact of life requires new skills. The nurse must not only advocate for these patients rights, but also negotiate with the patients about the perception of those rights and their associated responsibilities. The outcomes of these conflicts can be stressful.

These conflicts caused by lack of sound negotiation skills, disrupt relationships among people, leave expectations unclear and unfulfilled and create stress.

The Role of Women in the Hospital Culture:

Beliefs and values that women have about themselves as well as the beliefs and values that men have toward them constitute a part of the culture of the hospital. These beliefs and values don't emerge overnight. They are the product of long years of experience.

Women and men have been socialized from an early age to display attributes consistent with their gender. This is true in the workplace. Being aware of what historically has influenced women's behaviors motivates one to think and offers ways to act that are comfortable. If nurses, as women are aware that they are at an uneven table having less advantages then the men in these conflict situations, their chances of practicing new behaviors will increase. If the nurses recognize the various games that are being played in the environment, they can do something about it. One example is that when nurses are compliant, they are perceived as "good little girls". The physicians and hospital administrators including nurse administrators are comfortable working with them. When nurses drop this role, and begin to address conflict situations and negotiate, the "good little girl" becomes a liability.

The role of the women nurses in hospitals didn't happen overnight. In the world of early nineteenth-century America, almost every woman could expect to spend some part of her life caring for relatives or friends who were ill. Cultural expectations were formed in part by societal necessity, since few institutions relieved a family of this burden. Within the domestic boundaries of antebellum women's lives nursing played an important and inextricable part as caring and sacrifice became a poignant manifestation of female virtue. Caring for family members was central to a woman's self-sacrificing service to others. **(**Reverby, 1987).

After the Civil War, this cultural expectation moved into the newly constructed hospitals. More and more sick people were leaving their homes to be cared for in hospitals. While caring for patients, the nurse was expected to provide moral treatment and Christian nurturance. The hospital trustees eulogized Miss Sarah J. Wry, a nurse at the Massachusetts General Hospital, by saying "her moral influence over many a patient went further towards bringing about recovery than any other means she used. Remember her in the way she would most wish to be remembered, as the *Good Nurse".(*Reverby, 1987). Up until the present time, these conditions have created a profession that promotes compliance and conformity.

The hospital structures partly emerged along with and because of this culture. Physicians were in charge and the nurses were expected to defer to their authority and to keep the institution orderly and clean. Nurses learned to work around this system in order to care for their patients but the culture and structures strongly supported the physicians' opinions and control. A great deal has changed over the past two hundred years but

remnants of the structures and culture remain. For example, nursing is still a female profession. Ninety–five percent (95%) of nurses who practice are women. And nurses still have a different communication styles than their male physician counterparts. (Valentine, 2001).

Physicians, unlike the women nurses, have been men in power in health care organizations. They have held key leadership positions that allowed them to be able to influence the bureaucracy, like policies and procedures. They have held cultural authority and occupational control. This authority was more than just giving commands. The authority and control were related to their science, the definitions that they gave to health care phenomena and the rules and regulations issued by the various medical organizations. (Starr, 1982).

The role of gender impacts the way that men and women manage conflict. It addition, it influences women's use of negotiation skills. (Babcock & Laschever, 2003) describing the current work place issues that that women face, note that negotiation has always been an important workplace skill, but it has been considered the province of men. In this competitive realm men excelled and women felt less capable.

It is no different in hospitals. In today's health care environment, most nurses are women and as a whole, outnumber men six to one. (Walker, 1999). The complexity of the environment is requiring better communication skills in order to function. Today, the social forces that have constrained nurses are being exposed and this requires that nurses understand, at a very deep level, the forces that shape their beliefs, attitudes and impulses. In other words, nurses need to be conscious of the culture and the gender gaps that are shaping the current hospital structures.

The gender factor is significant when considering the context of the conflict situations that occur at the unit level. Again up until the most recent times, most physicians were men. The relationship that has developed between doctors and nurses is quite complex, varied and has had a rich tradition of role conflicts. Historically nurses' training emphasized the need to follow the orders of physicians. Many physicians expected the nurse to be their assistants. They believed that they had authority over nurses and struggled to maintain that authority. Physicians ignored their suggestions. In addition they also indicated that they did not want feedback.

The Role of the Nurse

The role of the nurse spotlights the intersection of organizational structure and culture. Today's nurses are more autonomous, are professional, and accept accountability for patient care. In addition, the various nursing roles have been expanded through advanced education and clinical research. In the hospital, nurses as a group spend more time with patients than physicians do and often have valid proposals for altering therapeutic measures.

The role of the nurse has conflict built into it. The expectations of the roles and the varied nursing responses can lead to role problems if there are unclear, ambiguous messages from the hospital administration. Role conflict also arises if the nurse receives different directions from different sources (e.g., physician, supervisor, patient, interdisciplinary personnel), each one, expecting compliance. Another problem occurs if a nurse is unwilling or unable to accept the norms associated with his or her role. Unless the problem is identified and resolved, stress and job dissatisfaction occur.

A second key characteristic of a nurse's role that is a source of conflict is the multiple roles and the various personnel with whom she works during a typical day. The nurses' presence provides surveillance of patients. In addition, nurses provide therapeutic nursing interventions and treatments to carry out medical orders. Nurses serve as the integrator or coordinator of patient care. These integrating activities include implementing physician treatment orders and explaining them to the patient; planning for the patients' discharge, from hospitals, (IOM, 2004).

The hospital environment is extremely conflict ridden and the nurse needs to be able to interact with this increasingly complex and very competitive environment. Their ability to negotiate directly impacts their ability to care for patients. Nurse needs to be able to negotiate and address conflict, which is present in the everyday delivery of patient care in our hospitals. (Douglass 1996) The greater the responsibility that the nurse has brings with it more interaction and accountability for the care that patients and their families receive. The nurse's ability to manage conflict and negotiate the system in the acute care setting of a hospital can directly impact the patient's experience.

Meanings and impact of power

Deutsch (1973) outlined the conditions for "effective power" as having control of the resources to generate power, motivation to influence others, skill in converting resources to power, and good judgment in employing power so that it is appropriate in type and magnitude to the situation. Deutsch (1973) also describes power as being a relational concept functioning between the person and his or her environment. In this view, power, therefore is determined not only by the characteristics of the person or persons involved in any given situation, nor solely by the characteristics of the situation, but by the interaction of these two sets of factors.

In order to successfully care for patients, nurses need to control the resources to care for patients or be able to motivate and influence others to acquire those resources, and then to practice with knowledge and skill in converting those resources into excellent patient care all the while, employing good judgment to achieve successful outcomes. Negotiation skills assist the nurses achieve this end. Negotiation skills are a pathway to influence and direct patient care.

In order for nurses to care for patients they need to have access to the resources necessary for that care. For example, if a patient needs to have a special bed because the patient has is a potential for skin damage, the nurse needs to be able to get that bed at the right time and to the right place. If the nurse is able to negotiate for the bed, the patient will be able to get the bed and her clinical outcome may be improved. Quality care is the objective but negotiation skills give the nurses the opportunity to engage others towards achieving that goal.

The nurses' ability to understand others and approach the negotiation with an awareness of distributive justice provides an opportunity for nurses to move from avoidance behaviors to other more competitive and collaborative negotiations.

Historically as discussed above physicians and administrators were perceived as having more power than nurses. However, the patient required the knowledge and skill of both the physicians and the nurses in order to achieve the desired clinical outcomes. The prevailing assumption that the physicians and the patients held was that physicians were the most critical factor in achieving these good outcomes. Historically, the patient deferred to the physicians because of their clinical knowledge and the administrators deferred to the physicians because they generated money for the hospital.

There was general believe on the part of all players that the physicians had the power and that the nurses did not. If the nurse is unable to motivate the physician to her plan, the patient's condition could be at risk. The times are changing and as discussed above, the critical function of the nurses in patient care is becoming understood. If nurses can learn how to negotiate especially from a distributive bargaining perspective (in the beginning) they will be able to increase their ability to understand the mindset of physicians and administrators and will not be so apt to avoid conflict. They will have a better understanding of conflict's nature and will have a facility to see the other side's point of views and be able to develop alternative approaches to resolving the conflicts.

Historically, a common pattern in the hierarchy of nursing can be seen in supervisors' unfeeling attitudes toward their subordinates. This often has contributed to the breakdown of trust among nurses and thus to a weakening of their power base in the hospital organization, (Pinkerton and Schroeder, 1988).

Summary

Nurses face conflicts arising from 1) the various and many changes in the structure of the hospitals, 2) a culture of conflict avoidance resulting from a gender issues and inadequate training, and 3) the power imbalances resulting from the multifaceted and ambiguous role definitions of nurses in the hospital. Negotiation skills provide nurses with competencies that can help them constructively address these problems. Negotiation skills are vital for successfully bridging the environmental/personal relationship. Nurses play a significant role in directing the day to day of a patient's experience.

It is necessary that nurses move from avoiding and compromising modes to ones that are more competitive, and eventually cooperative. The decision to highlight

distributive/competitive bargaining was not to advocate that this is the best bargaining method to use but to help nurses to see how many of the people with whom they interact in a hospital setting use this type of bargaining.

The premise is that if they understand the others' methods they will be willing to learn alternative methods. Because of the trend for more participatory structures, negotiation skills will become absolutely necessary.

Case Study: Training at Massachusetts General Hospital

The two hour session, "Negotiation Skills for the Acute Care Staff Nurse" provided an opportunity to develop a curriculum and test the training methods for teaching negotiation skills. Assisting nurses to understand the necessity for skilled negotiation, helping them develop assessment skills to understand their personal style of negotiation, and identifying methods for assessing, evaluating and implementing these negotiation skills was the goal of the project.

The purpose of the session was to introduce staff nurses to the concept of negotiation, the basic languages used in negotiation and the competencies that they might develop to use in their every day practice as they experience conflict in patient care. The following elements are the components of the curriculum and the associated methodologies

- **Introductions:** The session began with the participants introducing themselves, describing where they worked and what they expected from this two-hour session. They were then asked to describe some conflict situations, which they had experienced in their practice. The goal was to assess the group's understanding of the various types of conflict situations and their responses to them. Questions elicited comments with the assumption that all nurses have been in these situations. Rich discussions and sharing of experiences emerged. The realization that everyone had experienced conflicts in their practice created a climate that they all were having similar experiences. The objective addressing assessment included eliciting from the participants their perceptions of a need to negotiate in their everyday experiences delivering care to patients. In addition, assessment questions about practicing in a competitive environment were addressed. My assumption was that few nurses reflected on the culture of the hospital as a competitive environment for themselves and their patients and this impacted their negotiation styles.

- **Power Point Presentation:**
- Definitions of Negotiation: Example of definitions. Negotiation includes all cases in which two or more parties are communicating, each for the purpose of influencing the other's decision.
- Types of Negotiations:
- Integrative and Collaborative Bargaining was discussed but emphasis was placed on Distributive Bargaining: This bargaining is a competitive or win-lose bargaining type. This type of bargaining may be used when the goals of one party

are usually in fundamental and direct conflict with the goals of the other party. The resources are fixed and limited and each party wants to maximize their share of the resources. As a result, each party will use a set of strategies to maximize the share of the outcomes to be obtained.

- Rationale for Distributive Bargaining: This conceptual framework closely resembles the environment that the nurses find themselves in, and is a concept that staff nurses can identify with. This type of bargaining and negotiation was most familiar to the participants when they negotiate in situations that are outside the hospital culture. They were more proficient in this type of bargaining in their every day experience e.g., buying a house, or purchasing a car. In addition, the intent was to introduce the nurses to the idea that they would be able to reframe their usual avoidance style used in the hospital situation by using competitive/ distributive bargaining techniques. The ultimate goal was that patient care could be improved.
- **Elements of Distributive Bargaining**
- Starting the Negotiation: The role of planning in the process was discussed and highlighted.
- Setting the Targets: Becoming aware that one could set targets and begin to visualize new possibilities was introduced.
- Forms of Resistance: Two tasks are important in all distributive bargaining situations. They are discovering the other party's resistance point and influencing the other party's resistance point.
- Bargaining Range: The goal is to begin to realize that others in a negotiation process have some idea of how flexible or inflexible they need to be.
- Settlement Range: The fundamental process of distributive bargaining is to reach a settlement within a positive bargaining range. The objective of both parties is to obtain as much of the bargaining range as possible.
- Zone of Potential Agreement: This allows the one to become more flexible in planning.
- Role of Alternatives to Negotiated Agreement: The role of alternatives to negotiated agreement is important as it gives the negotiator the power to walk. In negotiations where one has many attractive alternatives, one is able to set goals and make fewer concessions. Nurses describe the experience they have of being in moral distress if they were to resist the other party for fear of patient abandonment. It may be described as the major reason why they avoid conflict. They don't usually see it as possible that they could walk away from a negotiation.
- Bargaining Mix: Negotiators need to know what is important to them and to the other party, and they need to make sure they take these priorities into account during the planning process. Each item in a bargaining mix can have opening, target and resistance points. The bargaining mix may provide opportunities for bundling issues together, logrolling, or mutually concessionary behavior.
- The context of the negotiation into a context: Nurses do not have a lot of time to carve out negotiation time. They need to recognize that the moment when they are in a negotiation and realize that the negotiation is happening. Time is of the essence here. For example, a nurse in busy ICU could have resident physician

schedule a test for a patient and the nurse having two patients who had to go for tests could not take both patients to the different testing sites. The various options need to be explored with the resident, testing sites and taking in consideration of the needs of each patient.

- The management of impressions and perceptions. This aspect of negotiations is an important component for nurses. Taking direct action to alter impressions and modifying the other party's perceptions is not a skill that most nurses are conscious of having. Introduced the concept of making outcomes appear less attractive, making the cost of obtaining them appear higher and interpreting the outcome of the other parties' proposal. Encouraging participants to manipulate the actual costs of delay or termination by disruptive action, allying with outsiders and scheduling of negotiation is new behavior for many nurses.
- Planning
- Assessment: Assess the situation as quickly as possible. Figure out how to find information, phone call, personal contacts, reviewing schedules. Try to find out what you don't know ahead of time.
- Opening offer; examples of opening offers are given.
- Opening stance: consider the approach that you are going to take. Assess your mindset, will you be competitive or more moderate
- Initial concessions: give something to gain something more important.
- Patterns of concession making: Example of selling a house. Develop good will.
- Final offer: Needs to meet both parties need if it is to be enduring.
- Commitment;
- Tactical considerations in using commitments
- Establishing a commitment
- Tactics used in negotiation were then introduced**.**

- **Tactics used in distributive/competitive bargaining**
- Hardball,
- Good guy/bad guy,
- Highball/lowball,
- Bogey, Being transparent Not every one will let you see what they want.
- Aggressive behavior,
- The nibble, small concessions
- Playing chicken
- Intimidation
- Conclusion The conclusion was that to be successful both parties to the negotiation must feel at the end that the outcome was the best that they could achieve and that it is worth accepting and supporting

- **Interactive Work: Dyads:** The purpose of this section of the session was to practice some of the skills which had been described. Each dyad was given a scenario, which had been developed from personal experiences encountered in previous leadership positions. The scenarios described conflict situations between nurses in different departments in the hospital. (Appendix). .

Summary

The message that I hoped to deliver was that to be successful both parties to the negotiation must feel at the end that the outcome was the best that they could achieve and that it was worth accepting.

Evaluation

One hundred and fifty-one staff have attended 6 programs programs. The session took place on the hospital campus in the training and development classrooms.

The results of the evaluation are described in table 1.

Session	#1: 2/26/03			#2: 6/19/03		
Number of Participants	39			31		
Objectives	Met	Partially Met	Not Met	Met	Partially Met	Not Met
Obj. 1. Identify personal style of negotiation	0	0	0	22	8	1
Obj. 2. Identify methods for assessing, evaluating implementing negotiation skills	36	3	0	26	4	1
Session	#3 11/13/03			#4 02/5/04		
Number of Participants	30			21		
Objectives	Met	Partially Met	Not Met	Met	Partially Met	Not Met
Obj. 1. Identify personal style of negotiation	23	7		11	10	
Obj. 2. Identify methods for assessing, evaluating, & implementing negotiation skills	27	3	0	17	4	

Negotiation Session	#5: 10/29/04			#6: 06/2/05		
Number of Participants	15			15		
Objectives	Met	Partially Met	Not Met	Met	Partially Met	Not Met
Obj. 1. Identify personal style of negotiation	0	0	0	13	2	
Obj. 2. Identify methods for assessing, evaluating implementing negotiation skills	14	1	0	14	1	

Evaluation summary

Ninety seven, (97) participants out of a total of one hundred and fifty-one (151), sixty-four percent (64%) responded to the first objective: identify person style of negotiation. Of the 97 participants, 69, or 71% rated the objective as having been met and 27, or 28% rated the objective as partially met. One participant rated the objective as not met. This low rate is probably due to the fact that an assessment instrument was not used in 5 of the six sessions.

In contrast, one hundred and fifty-one (151) participants responded to the second objective: identify methods for assessing, evaluating and implementing negotiation skills. One hundred and thirty-four (134) or eighty-nine percent (89%) rated objective 2 as having been met. While sixteen (16) or eleven percent (11%) rated objective 2 as partially met. One participant rated the objective as not met. This score was higher than objective 1.

Based on these evaluations, I would introduce an assessment tool into the workshop. The Thomas Killman Inventory has the potential of assessing styles that can be compared to other studies. I will consider this tool in the future

Epilogue

I learned many lessons from this project. I discovered that there was interest in a program that would offer negotiation skills and that staff from several role groups would come if it were offered. In order to infuse this program into the already established programs it was

necessary for me to assess what programs were already in place and to offer to fill the gap. There are many more gaps to fill.

I have determined that this subject of negotiation skills and conflict is a subject that staff would like to learn more about from someone like myself who knows some of the issues they face. I believe this is the first of many programs that I would like to offer and that this is only the beginning phase of a much larger study. Introducing staff nurses to the concept of negotiating in the workplace to make work culture a more satisfying experience for themselves and their patients and families is for me a life-long commitment.

Organizations have identified the need to monitor patient and staff satisfaction and many have surveys that make an attempt to assess such subjects as conflict in the workplace and satisfaction with the overall work environment as well as the patient care experience. It is my belief that it is these types of workshops that allow staff to discuss the conflicts they are having and to strategize about realistic ways to negotiate when conflicts arise will begin to provide staff the skills to effectively address issues at the grassroots level.

An ongoing program is necessary with hospital-wide attention to these matters in necessary for a true cultural change to occur. We are on the edge of what I believe to be a long awaited revolution that brings to the forefront of healthcare an ever- increasing understanding that recognizes that all heath care workers need to address conflict in the workplace. Our patients depend on us to address such issues as they are at our mercy and rely on us to facilitate all aspects of care. I do not underestimate the enormous amount of education that must take place with all health-care providers to begin to address these concerns and know that with each and every program we have reached more and more staff to have these conversations. One person at a time, I hope to be part of this movement.

Finally, as I go forward, developing my thinking on this subject, I shall be addressing the issue of ethics in all of this. Ethics is an integral part of the foundation of nurse. And the American Nurses Association has developed a "Code of Ethics for Nurses with Interpretive Statements". (ANA, 2001) Nurses will not be able to implement these standards if they avoid conflict. Negotiation skills will assist in their implementation.

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