Negotiation Pearls (In Order of Response)

There is a great book called "getting to yes" that talks about collective bargaining and confrontation resolution.  that may give you some ideas. ~ Mark Silverberg

I like to bait consultants with a bit of flattery, letting them know how smart I think they are:

"I need your help with a really tough case. Can I tell you about it?"---the Butter 'Em Up

"I've got a case that only an Internist can solve. I'm just a dumb old ER doc."--the Slice of Humble Pie

Sometimes it comes down to a cool case for residents:

"I've got a case that would be a great teaching opportunity for your residents."--the Academic Sound Bite

If that fails, a little passive aggressive attitude involving the chair of MOD never hurts:

"Well, I could call your chair and discuss it further with her, but it's 3am and I think she operates in a few hours."--the Not-So-Veiled-Threat ~David Barnes

these are good resources from ALiEM blog with expert opinions. I've referenced these for a talk and workshop I did with my residents on the topic

[http://www.aliem.com/improving-consultation-communication-skills/](https://webmail.templehealth.org/OWA/redir.aspx?SURL=noKlYW6CRUg_gfFBgk1JxKUfeUpiRLOsTsuQo7irRcqHjOwOJCPSCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBhAGwAaQBlAG0ALgBjAG8AbQAvAGkAbQBwAHIAbwB2AGkAbgBnAC0AYwBvAG4AcwB1AGwAdABhAHQAaQBvAG4ALQBjAG8AbQBtAHUAbgBpAGMAYQB0AGkAbwBuAC0AcwBrAGkAbABsAHMALwA.&URL=http%3a%2f%2fwww.aliem.com%2fimproving-consultation-communication-skills%2f)

[http://www.aliem.com/medic-series-the-case-of-the-difficult-consult/](https://webmail.templehealth.org/OWA/redir.aspx?SURL=ZHrOYdP1US_LNTaGLZFIcyNldN9dMLO9B9x0kH4gFnmHjOwOJCPSCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBhAGwAaQBlAG0ALgBjAG8AbQAvAG0AZQBkAGkAYwAtAHMAZQByAGkAZQBzAC0AdABoAGUALQBjAGEAcwBlAC0AbwBmAC0AdABoAGUALQBkAGkAZgBmAGkAYwB1AGwAdAAtAGMAbwBuAHMAdQBsAHQALwA.&URL=http%3a%2f%2fwww.aliem.com%2fmedic-series-the-case-of-the-difficult-consult%2f)

~Jordana Haber

Typical advice is to say: "I need your help with a patient", have pre-existing familiarity via med staff functions, getting out of the fishbowl, etc.

I believe the policies we have on admissions agreed to between services like the ortho and uro one we have is good to defuse 2 AM issues. ~Robert McNamara

I can remember Sandra Day (an ED physician at Fairfax) who was the master of this.  This requires better than average situational awareness.  If you just sent your surgeon to the OR with an appy she would ask before they go into the case if there was anyone else they can call for routine surgical consults.  When they called back and said "this is ENT on call", She asked their name immediately and addressed them by their name.    
1.  She was very courteous to her consultants when they came in.  Gave them coffee when they arrived at the middle of the night.

2.  She had a very clear question.  IE I need to know if this patient has angioedema around their vocal cords.  OR I'm worried that this patient has ischemic gut and pain out of proportion to his exam.

3.  My favorite was when there was a rather irate admitting attending at 2am and she handed the spectralink phone over this her patient and said "Tell your patient why you don't want to admit them"

4. Also know what your consultants are comfortable with doing.  I once asked my trauma surgeon to do a thrombectomy and he laughed at me.

5.  When I become faculty at a new institution I go to consultant grand rounds and I round with them in the am a few times to understand processes. This helps with knowing the level of care different places can handle and also get them to know their name.

6.When a consultant is waiting for you to sew up their hand that they cut on the garbage lid,  treat them like royalty.  prioritize them high and check up on them.  It has paid dividends in the long term with calling in the middle of night, especially with difficult consultants

7. When it doubt always bring it back to the patient.  IE> the patient has been down here for 16 hours and that PE CT will not change management and they are developing bedsores and I can't get a consult to cardiology because they don't come down to the ed.. ~Rodney Omron

I use silence to my advantage. If that does not work, very simple common sense talk.

~Mike Takacs

Like any "rules" of negotiations, there are some general principles that tend to work (and those that don't):

1) "Learn all you can about the other party" or in this case, know the consultant outside of the ED. This means sitting/working with them on hospital committees, meeting them in the doctor's lounge, social with them (\*gasp!\*), etc. Once they know you by face, they are much more likely to do what you ask of them.

2) "have a (reasonable) plan and prepare your arguments" - I've watched both residents and attendings call a consultant and try to sell a weak story to them. When asked by the consultant why they thought they (ie the consultant) they needed their service, the worst answer has always been "I don't know, that's why I'm calling you!" Basically it shows that the ED provider is nothing more than a triage doc who doesn't understand much of anything.

3) "Listen (and be nice)" - It's important to listen to the consultant if they give pushback or "critiques" and to acknolwedge them. I always repeat back (with their words - standard leadership training tactic) to them what they say and say things like "I understand" or "good point". From there you can sometimes negotiate a happy medium. Also, it's amazing how  few compliments/jokes can break the ice and make the consultant feel more comfortable, like the hospitalist who just took on 8 admissions the last hour and now you have 2 more for that person (I like to start off with a line like, "I have some more productivity boosters for you!")

4) "develop relationships" - sometimes if the consultant got dumped on by another hospital (which usually comes through the ED), I will sympathize with the consultant and promise them that I will follow up with admin in the morning about it, and that we will circle back to the sending hospital about "appropriateness" (we've even threatened other hospitals with EMTALA and such if they continued). If the complaint is about an ED provider, I will always promise to review the case and if appropriate, give necessary feedback to the ED provider for improvement. I do circle back to the consultant so they know what the outcomes are so they know that the ED will advocate for them also. Periodically I will ask for feedback from various outside departments in how we can better serve them (which in turn, I will then have a few 'recommendations' on how they can help us).

Lastly (and only lastly), do I threaten a consultant with either what's in our medical staff bylaws or EMTALA. This may will the battle, but may cost you the war. However, it's may be necessary, but is something that the ED provider should understand well (And how to escalate when all else fails - I will say thing is something that I think most ED providers don't understand and often they will inadvertently violate these rules). ~Bruce Lo

Depending on the consultant, sometimes I'll play to the ego a little bit by starting with something like "we could really use your help with this one..." Or "this patient really needs a (insert specialist here)"  
  
Sets the framework of the conversation.  
  
They generally think we're incompetent and helpless anyway. ~Richard Byrne

I forget where I learned it, but I like using the phrase "as you know...".  For example, "as you know Dr. Cards, Sgarbossa criteria can be used to show this pt has a high probability of ruling in for acute occlusion".  When things have derailed, I'll simply say "you are a doctor, you can come discharge the patient."  It rarely comes to this though. ~Cam Mosley

My favorite points to make:

1.  Use The Hammer - "I think this is in the best interests of the patient".

2.  Diagnose your consultant and give them the information the way they want it: the binary question for the surgeon, the sob story for the psychiatrist, the data deluge for the internist, etc. etc.  (stolen from Chad Kessler)

3.  Getting their name and a commitment on when they are coming to see the patient.

4.  Everything is negotiable (you call with a young man with RLQ ap that can only be an appy, the surgeon asks for the CT scan, and you negotiate that you will get their CBC and make sure they are in a room, but if they laid hands on the patient you think they would agree that this is an appy and needs the OR without a CT).

5.  The power of silence - when they are disagreeing, let them talk.  Let them talk themselves right out of not helping.  Makes them justify why they should not be involved instead of listening to you build a case.   ~Adam Kellogg

2 things have worked for me.  1 - when I don't totally agree with a consultants plan/suggestion and ask questions just because i want to understand, consultants have become defensive. In those situations, I often now preface with something like "Thank you for your input.  This is your speciality and I value your opinion but I am not clear on a few things.  Can you please explain to me 'whatever the issue may be' just to better educate me so next time, i may not need to call?"  A lot of times, we end up coming up with a great plan somewhere in the middle, we had an open collegial discussion and i have the groundwork to continue building that relationship with said consultant.  2 - some of our consultants are not up on their own literature.  many times, i will very politely say, "as you know" and make the statement about their literature they should know and do not to make a point.  for example, our hospital lab uses a d dimer of greater than 220 as "abnormal".  This is not consistent with the chest guidelines of a negative dimer is considered less than 500.  So, as I'm attempting to admit someone for which i already used a dimer to rule out pe in the appropriate clinical setting, I say something like, "The dimer was 350.  As you know 'quote chest guidelines', so i did not perform any imaging studies". ~Annahieta Kalantari

I have found that the use of *Principled Negotiation Strategy* works fairly well for all except the most recalcitrant consultants. While the formal process of principled negotiation maybe too painstaking for a quick interaction, the principles are the same.

Separate the people from the problem **-  where is this patient best served and how do we get them taken care of?**

Focus on interests not positions-   **why is the consultant putting up barriers? What are their interests?   Think about why they are not doing what you want them to do.**

Invent options for mutual gain-     **are there any solutions that help you and help them at the same time and still get the patients served well?**

Insist on using objective criteria-   **are there any pre-existing objective criteria, processes, protocols, Or agreements that I have relevance to the question?**

I have found that when I deal with difficult consultants, thinking about what their interests are, and why they are being difficult, really helps me figure out how to get them to do what is best for the patient. Hopefully, this is what I want them to do as well. Sometimes, we call consultants and try to get patients admitted to the wrong service because it makes our lives easier, when consultants put up resistance to this, they are doing the right thing. We always have to make sure that we are doing the right thing for the patient, and not for ourselves. ~Christopher Doty

Be aware of policies and procedures. It may take some digging but there is a Med Exec policy about expected response times for consultants. Occasionally helpful to be aware of this and may be worthwhile to incorporate this into the discussion.

Calls to consultants need to be goal oriented and should be presented in an assessment oriented fashion. I hear our residents frequently call consults and spend 2-3 minutes regurgitating the entire HPI before they ever say why they are calling the consult.

People need to out themselves in the consultants shoes. Is it emergent?  If not, do not call in the middle of the night? Also think it is important to go out of your way to help your consultant when they come to the ED. May be as simple as getting up to introduce yourself. Maybe it is meeting them at the bedside to give a more thorough history or asking if they need anything, etc. This can go along way in building collegial relationships.

Alternatively, do not tolerate any unprofessional behavior and in turn if there is an issue resolve it in private not in public.

Document discussions with consultants in the EMR.

Be knowledgeable. If it's a cards case. Be aware of Old ECG, cath, echo, etc. Of you are knowledgeable about the case and speak with conviction, it says much for credibility.

Lastly, as I mentioned earlier be goal oriented. Why are you calling the consultant. Do you need them to come to the bedside, do you need guidance regarding a clinical issue or to arrange follow up.

~David Wald

I've always found phrases like

- Its out of my depth, the patient needs your expertise

- This patient would really benefit from your help

- I don't feel comfortable sending them home without your input/expertise/help

by pfocusing on the patient needs and their 'calling' to help them, you make it less personal between the ED staff and the consultant... ~Gene Hern

I would say that this is similar to many conflict resolution strategies.  First, identify what the bottom lines are (i.e. what do you believe you absolutely need from the consultant) so that you make sure that you say this.  Second, when a situation escalates, try to understand the subtext of the conversation (ie. did the consultant recently have "bad" admissions from the ED, are they tired, etc.) - often the consultant may need to air these issues first and we need to be therapeutic in responding to those issues first.  Third, we need to make sure that the conversation is patient-centered (often the conversation can devolve to the personalities involved, we always have to be willing to take the higher road).  Fourth, listen to what the consultant.  Often, our consultants are excellent resources and may be able to create alternatives that work better for the patient if we listen to them.  As EM docs, we can get fixated on our original plans so we need to remain flexible, keeping the patient advocacy as the top priority.  Lastly, always let the consultant know how much you appreciate their participation/assistance/etc., this is truly an opportunity to build the relationship, even when it may have started on the wrong foot, this is especially important when the consultant has behaved less than professionally, we should still be the bigger people, take a deep breath and allow for a certain amount of gratitude to infuse the conversation.  It does come back in the end and benefits our patients.

~Fiona Gallahue