ETHICAL PERSPECTIVE

Negotiating behavior changes with patients who have diabetes: negotiation or coercion?

Robert M Anderson* & Martha M Funnell

Practice Points

- Negotiating with patients to get them to make positive changes in their lifestyle behavior is widely used by various healthcare professionals across a variety of health issues.
- Negotiation is frequently touted as a patient-centered strategy because it requires healthcare professionals to be flexible regarding their recommendations to patients about lifestyle change.
- However, a careful examination of such negotiation reveals that negotiation is, in actuality, professionals using the hierarchical power in their relationships with patients to get patients to change their behavior.
- When negotiating behavior changes with patients, healthcare professionals should be fully aware that what they are actually doing is using their hierarchal position in the relationship to pressure their patients to change their behavior.
- We hope that after thinking carefully about negotiation a significant number of healthcare professionals will consider more patient-centered approaches as an alternative to negotiation.

SUMMARY Negotiation as a strategy for getting patients to make lifestyle changes has been used in diabetes as well as other chronic diseases for over 20 years. It is thought of as a patient-centered technique because it requires healthcare professionals to be flexible with regards to their recommendations. However, when the process of negotiating with patients is examined closely, it is apparent that it lacks one of the major elements required for equitable negotiation. Negotiation as it is applied in counseling patients with diabetes is actually a form of coercion, such as a way pressuring patients' to change their behavior. Because of the discrepancy between what negotiation appears to be and what it actually is, we question whether it has a place in truly patient-centered care.

Negotiation as a means of getting patients to adopt healthy lifestyle behaviors is recognized as a useful strategy [1–26], it is used frequently in diabetes [1–14]. Negotiation is also used across a wide variety of illnesses and health disciplines. It is applied by physicians [2,12,18], dieticians [7] and nurses. In fact, in the nursing literature, expertise in negotiating with patients is considered fundamental; it should be part of the skill set of all nurses [15–17,24]. In addition to its use in diabetes,

Department of Medical Education, Michigan Diabetes Research & Training Center, Room G1208 Towsley Ctr. 0201, Ann Arbor MI 48109, USA
*Author for correspondence: Department of Medical Education & Senior Research Scientist, Michigan Diabetes Research & Training Center, Room G1111 Towsley Center 0201, Ann Arbor MI 48109, USA; Tel.: +1 734 763 1153; Fax: +1 734 936 1641; boba@umich.edu

Future Medicine part of fsg

negotiation is also used therapeutically to influence a variety of health-related behaviors including obesity [24], adherence [22], smoking [10] and physical activity [18–20]. It is safe to say that negotiation is a core strategy for helping patients make lifestyle changes to improve their health. Negotiation is also widely touted as an example of patient-centered care. It is thought to represent a shift away from paternalistic healthcare to much more patient-centered approach [27–41].

Although it is widely practiced and offered as an example of patient-centered care, we believe that what appears to be equitable negotiation between healthcare professionals and their patients is in fact coercion.

We begin by providing a hypothetical example of a negotiated agreement between a physician and his patient. The following examples have been somewhat exaggerated to facilitate comparison.

Example 1

This example describes a routine visit to a primary-care physician by a patient with type 2 diabetes. The physician says to the patient "I also remember from our last visit that I spent some time explaining the health benefits of exercise. I told you that walking briskly for 150 min a week would help you control your diabetes and lower your risk of complications such as having a heart attack. You said you would think it over. Have you thought about my recommendation?"

The patient: "I did think it over, but I realized that exercise is not my thing. In the first place I don't have anywhere near enough time to walk 150 min a week. And I'm pretty sure I wouldn't enjoy walking for exercise even if I had enough time."

The physician: "Did I explain the benefits of walking clearly?"

The patient: "Absolutely doctor I understood everything you told me. Let's face it doctor, I'm just not an 'exercise' person."

The physician: "Just to be safe…" The physician briefly reiterates the benefits of aerobic exercise. "Do you have any questions?"

The patient: "No doctor I don't have any questions. And just like last time I understood everything you told me."

The physician: "I have an idea. Let's see if we can negotiate a compromise. Will you agree to try walking for 60 min a week? This plan addresses your two main objections to walking. It requires far less time than the 150 min a week. In fact, you don't have to do the 60 min all at once. You could take two 30-min walks or even four 15-min walks. And if you found a pleasant place to walk like a park you might even discover that you can enjoy walking. So how about it, can you commit to walking 60 min a week?"

The patient: "OK doctor I'll give it a shot."

Was the agreement reached by the physician and the patient the result of equitable negotiation? The example below of equitable negotiation will help answer that question.

Example 2

Mr Jones wants to purchase Mrs Smith's home so they meet to negotiate a price. Mrs Smith is asking $300,000 for her home. Mr Jones says, "I think $300,000 is much too high but I am willing to pay $260,000." Mrs Smith says "My house is worth more than $260,000 but I'll come down to $290,000."

Mr Jones replies "That is still more than I'm willing to pay but I will come up to $270,000." Mrs Smith responds by saying let's compromise and split the difference. I will come down another $10,000 if you are willing to come up another $10,000." Mr Jones says, "I can live with that." Now they are in agreement and the house is sold and purchased for $280,000.

An equitable negotiation requires two fundamental elements to be in place. First, both parties must want what the other party has. Second, both parties must be willing to withhold what the other party wants if they are not satisfied with what the other party is offering. The willingness to withhold what the other person wants is the source of the power that each person brings to negotiation.

Negotiations of this kind are common in everyday life, for example the customer and the car salesman negotiate the price of a car; the labor union and the company negotiate the wages for the next year.

Discussion

Let us examine the negotiation between the physician and the patient in light of the above example to determine if the required elements for an equitable negotiation are in place. Do both parties have something the other wants? The answer is yes. The physician wants the patient to exercise to improve his health. The patient wants to maintain his therapeutic relationship with Cameron (i.e., the doctor's approval and good will). However, the patient needs what the physician has far more than the physician needs anything that the patient has.

This is a hierarcacal relationship because the distribution of power (i.e., the means to influence the behavior of another person) between the two parties is unequal and favors the physician. This unequal distribution of power is the basis of the traditional paternalistic relationship between physicians and their patients. Is it possible for equitable negotiation to take place in a hierarchal relationship? The answer is no. The vulnerability of patients in the physician–patient relationship is the reason that it is considered unethical for physicians to date their patients, borrow money from them or sell them a used car and so on.

Does the physician's power arise from what he is willing to withhold from the patient if he refuses to negotiate? The answer is no. The great majority of physicians are ethical, compassionate and would continue to care for their patients in the way they do no matter how the negotiation turned out. In reality the patient has no reason to negotiate because there is nothing the physician would withhold from him if they didn't reach a compromise. In other words the patient has nothing to gain by negotiating and nothing to lose by refusing to negotiate. He is in a position to say to the physician. "I really like you doctor but given the fact I don't want to exercise I can't think of any reason why I should negotiate." But he does not say that, instead he agrees to negotiate with the physician about exercise. So the question becomes, why does he agree to negotiate?

The most likely explanation for the patient's willingness to negotiate is that he does not want to risk losing the approval and good will of the physician by appearing unreasonable and stubborn. The fear of incurring the disapproval of their physician is said to influence the choices patients make in a number of situations including the decisions patients make about joining clinical trials being conducted by their physician and agreeing to follow their physician's treatment recommendations [42–53]. Another possible explanation for the patient's willingness to negotiate is that he wants to avoid having to sit through a lecture from the physician (it is irrelevant whether or not being lectured to was a real possibility). His behavior again testifies to the hierarchal nature of the relationship. Parents lecture their children, teachers lecture their students and physicians lecture their patients. It is hard to imagine a situation where the patient would lecture the physician.

In a hierarchal relationship with a significant disparity of power favoring one party (i.e., the physician) equitable negotiation is not possible. Fortunately our society is moving away from a paternalistic approach to healthcare to more patient-centered care. On the surface negotiation between healthcare professionals and their patients appears to be an important step in the right direction toward patient-centered care. However, in this case that appearance is an illusion.

The problem is that what appears to be an equitable negotiation is in reality a way of putting pressure on patients to change their behavior. It is well-intentioned pressure, but pressure nonetheless. This is the reason why negotiation is not part of the empowerment approach. The empowerment approach is a patient-centered approach to collaborative care in which the goal is to help patients make informed, autonomous decisions about the self-management of their diabetes, based on a thorough knowledge of diabetes self management and clarity about their health-related priorities. Pressuring patients has no role in empowerment approach to diabetes care [54–60].

The following is an example of the same visit, but in this example the physician uses the empowerment approach.

Example 3

During the latter part of the visit the physician says to the patient, "I also remember from our last visit that I spent some time explaining the health benefits of exercise. I told you that walking briskly for 150 min a week would help you control your diabetes and lower your risk of having a heart attack. You said you would think it over. Have you thought about my recommendation?"

The patient: "I did think it over, but I realized that exercise is not my thing. In the first place I don't have anywhere near enough time to walk 150 min a week. And I'm pretty sure I wouldn't enjoy walking for exercise even if I had enough time."

The physician: "Did I explain the benefits of walking clearly?"

The patient: "Absolutely doctor I understood everything you told me. Let's face it doctor I'm just not an 'exercise' person."

The physician: "Ok – but before you leave I want to make sure that we are both clear on two things. First, walking is not about pleasing me; it is about keeping you healthy. As we discussed,

there is a lot of research showing the many benefits of exercise. Also, if you exercise three-times a day for 10 min you get the same benefit as you would from one 30 min exercise session. Second, I'm aware that we are talking about your life, not mine. I understand that when it comes to your life you're in charge. You have the right to make choices that you believe are in your best interest, even when we disagree. But I'm concerned about you and I hope that you at least continue to think about the contribution that regular exercise could make to your health."

The patient: "That I can do doctor."

Conclusion

Are we recommending that healthcare professionals stop using negotiation as a strategy for helping patients' change their behavior? The answer is no, because we recognize and respect the right of healthcare professionals to choose whatever strategies they believe are in the best interest of their patients. We wrote this article because we believe in the value of making informed decisions both for healthcare professionals and patients. What is referred to as negotiation in diabetes care is in reality a form of well-intentioned pressure used to get patients to change their behavior. Is it the right thing to do? You decide.

Future perspective

In our judgment negotiating with patients will continue to be viewed as a valuable strategy for getting patients to modify their lifestyle behavior to improve their health. However, we hope that after thinking carefully about negotiation a significant number of healthcare professionals will consider more patient-centered approaches as an alternative to negotiation, for example the use of clarifying questions to help patients to choose their own goals.

Although negotiating effectively is a skill it is not (and we believe will not) be viewed as such by most healthcare professionals (with the possible exception of nursing where it has been identified as a skill) because it appears deceptively easy, such as simply propose a compromise between what the patient is doing (or not doing) and what the health professional wants the patient to do. However, a skilled negotiator listens very carefully to everything that the patients says and proposes a change in the patients lifestyle behavior that is particularly suited to the patient's personality, culture, resources, values and aspirations. Those healthcare professionals who recognize that negotiating effectively is a valuable skill will practice reflectively and look for opportunities to improve their ability to negotiate more effectively.

Financial & competing interests disclosure

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties.

No writing assistance was utilized in the production of this manuscript.

References

Papers of special note have been highlighted as:

- of interest

1 Karhila P, Kettunen TA, Poskiparta M, Liimatainen L. Negotiation in Type 2 diabetes counselling: from problem recognition to mutual acceptance during lifestyle counselling. *Qual. Health Res.* 13(9), 1205–1224 (2003).

2 Williams GC, Mcgregor H, Zeldman A, Freedman ZR, Deci El, Elder D. Promoting glycemic control through diabetes self-management: evaluating a patient activation intervention. *Patient Educ. Couns.* 56(1), 28–34 (2005).

3 Carroll AE, DiMeglio LA, Stein S, Marrero DG. Contracting and monitoring relationships for adolescents with Type 1 diabetes: a pilot study. *Diabetes Technol. Ther.* 13(5), 543–549 (2011).

- **Describes the use of technology to support contracts negotiated with adolescents.**

4 Kettunen T, Poskiparta M, Kiuru P, Kasila K. Lifestyle counselling in Type 2 diabetes prevention: a case study of a nurse's communication activity to produce change talk. *Commun. Med.* 3(1), 3–14 (2006).

5 Yawn B, Zyzanski SJ, Goodwin MA, Gotler RS, Stange KC. Is diabetes treated as an acute or chronic illness in community family practice? *Diabetes Care* 24(8), 1390–1396 (2001).

6 Stott NC, Rees M, Rollnick S, Pill RM, Hackett P. Professional responses to innovation in clinical method: diabetes care and negotiating skills. *Patient Educ. Couns.* 29(1), 67–73 (1996).

7 Pastors JG, Warshaw H, Daly A, Franz M, Kulkarni K. The evidence for the effectiveness of medical nutrition therapy in diabetes management. *Diabetes Care* 25(3), 608–613 (2002).

8 Woodcock AJ, Kinmonth AL, Campbell MJ, Griffin SJ, Spiegal NM. Diabetes care from diagnosis: effects of training in patient-centered care on beliefs, attitudes and behavior of primary care professionals. *Patient Educ. Couns.* 37(1), 65–79 (1999).

9 Martin MB, Larsen BA, Shea L, Hutchins D, Alfaro-Correa A. State diabetes prevention and control program participation in the health disparities collaborative: evaluating the first 5 years. *Prev. Chronic. Dis.* 4(1), A13 (2007).

- **Examines the impact the Diabetes Prevention and Control Project involvement with the Health Disparities Collaborative had on aspects of diabetes care at Federally Qualified Health Centers. One of the key strategies used by the Federally Qualified Health Centers is negotiating behavior changes with patients.**

10 Canga N, De Irala J, Vara E, Duaso MJ, Ferrer A, Martinez-Gonzalez MA. Intervention study for smoking cessation in diabetic patients: a randomized controlled trial in both clinical and primary care settings. *Diabetes Care* 23(10), 1455–1460 (2000).

11 Piette JD, Weinberger M, Kraemer FB, McPhee SJ. Impact of automated calls with nurse follow-up on diabetes treatment outcomes in a Department of Veterans Affairs Healthcare System: a randomized controlled trial. *Diabetes Care* 24(2), 202–206 (2001).

12 Williams GC, Lynch M, Glasgow RE. Computer-assisted intervention improves patient-centered diabetes care by increasing autonomy support. *Health Psychol.* 26(6), 728–734 (2007).

13 Varadarajan S, Fennessy L, McLean H. Product and service design for patient centered diabetes care. *AMJ* 2(13), 216–219 (2009).

14 Williams K, Prevost AT, Griffin S *et al.* The ProActive trial protocol – a randomised controlled trial of the efficacy of a family-based, domiciliary intervention programme to increase physical activity among individuals at high risk of diabetes [ISRCTN61323766]. *BMC Public Health* 4, 48 (2004).

15 Miller LC, Jones BB, Graves RS, Sievert MC. Merging silos: collaborating for information literacy. *J. Contin. Educ. Nurse* 41(6), 267–272 (2010).

16 Sahlsten MJ, Larsson IE, Sjostrom B, Lindencrona CS, Plos KA. Patient participation in nursing care: towards a concept clarification from a nurse perspective. *J. Clin. Nurs.* 16(4), 630–637 (2007).

17 Trnobranski PH. Nurse-patient negotiation: assumption or reality? *J. Adv. Nurs.* 19(4), 733–737 (1994).

18 Pinto BM, Goldstein MG, Depue JD, Milan FB. Acceptability and feasibility of physician-based activity counselling. The PAL project. *Am. J. Prev. Med.* 15(2), 95–102 (1998).

19 Swinburn BA, Walter LG, Arroll B, Tilyard MW, Russell DG. Green prescriptions: attitudes and perceptions of general practitioners towards prescribing exercise. *Br. J. Gen. Pract.* 47(422), 567–569 (1997).

20 Hillsdon M, Thorogood M, White I, Foster C. Advising people to take more exercise is ineffective: a randomized controlled trial of physical activity promotion in primary care. *Int. J. Epidemiol.* 31(4), 808–815 (2002).

21 Marcus LJ, Dorn BC, McNulty EJ. *Renegotiating Healthcare: Resolving Conflict to Build Collaboration (2nd Edition)*. Jossey-Bass, San Francisco, CA, USA (2011).

22 Ingadottir B. *Adherence in Diabetes: Challenges, Negotiations and Dialogues: a Phenomenological Study on The Concept of Adherence From Patients' Perspectiv*e. Lap Lambert Academic Publishing, Saarbrücken, Germany (2009).

23 Tyler DO, Horner SD. Family-centered collaborative negotiation: a model for facilitating behavior change in primary care. *J. Am. Acad. Nurse Pract.* 20(4), 194–203 (2008).

24 Tyler DO, Horner SD. Collaborating with low-income families and their overweight children to improve weight-related behaviors: an intervention process evaluation. *J. Spec. Pediatr. Nurs.* 13(4), 263–274 (2008).

■ **Describes a parent–child-based model of healthcare that is used to address health risks in children. The model combines a family-centered interaction approach, with brief negotiation strategies.**

25 Russell S, Daly J, Hughes E, Hoog Co C. Nurses and 'difficult' patients: negotiating non-compliance. *J. Adv. Nurs.* 43(3), 281–287 (2003).

26 Anderson JG. Consumers of e-health – patterns of use and barriers. *Social Science Computer Review* 22(2), 242–248 (2004).

27 Shields L, Pratt J, Hunter J. Family centered care: a review of qualitative studies. *J. Clin. Nurs.* 15(10), 1317–1323 (2006).

28 Newes-Adeyi G, Helitzer DL, Roter D, Caulfield LE. Improving client-provider communication: evaluation of a training program for women, infants and children (WIC) professionals in New York state. *Patient Educ. Couns.* 55(2), 210–217 (2004).

29 Larsen JH, Risor O, Putnam S. P-R-A-C-T-I-C-A-L: a step-by-step model for conducting the consultation in general practice. *Fam. Pract.* 14(4), 295–301 (1997).

30 Coyne IT. Parent participation: a concept analysis. *J. Adv. Nurs.* 23(4), 733–740 (1996).

31 Bensing J. Bridging the gap. The separate worlds of evidence-based medicine and patient-centered medicine. *Patient Educ. Couns.* 39(1), 17–25 (2000).

32 Perlin JB, Kolodner RM, Roswell RH. The Veterans Health Administration: quality, value, accountability, and information as transforming strategies for patient-centered care. *Am. J. Manag. Care* 10(11 Pt 2), 828–836 (2004).

33 Delbanco TL. Patient-centered care. *Bull. NY Acad. Med.* 72(Suppl. 2), S634–S638 (1995).

34 Dhurjati R. Patient-centered care. *Am. J. Nurs.* 111(3), 12 (2011).

35 Bergeson SC, Dean JD. A systems approach to patient-centered care. *JAMA* 296(23), 2848–2851 (2006).

36 Stewart M. Towards a global definition of patient-centered care. *BMJ* 322(7284), 444–445 (2001).

37 Laine C, Davidoff F. Patient-centered medicine. A professional evolution. *JAMA* 275(2), 152–156 (1996).

38 Davis K, Schoenbaum SC, Audet AM. A 2020 vision of patient-centered primary care. *J. Gen. Intern. Med.* 20(10), 953–957 (2005).

■ **Describes the seven attributes of patient-centered care. However, only 25% of primary-care physicians incorporate some of the seven attributes into their practice.**

39 Little P, Everitt H, Williamson I *et al.* Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ* 322(7284), 468–472 (2001).

40 Wagner EH, Bennett SM, Austin BT, Greene SM, Schaefer JK, Vonkorff M. Finding common ground: patient-centeredness and evidence-based chronic illness care. *J. Altern. Complement. Med.* 11(Suppl. 1), S7–S15 (2005).

41 Stewart M, Brown JB, Donner A *et al.* The impact of patient-centered care on outcomes. *J. Fam. Pract.* 49(9), 796–804 (2000).

42 Hewlett S. Consent to clinical research-adequately voluntary or substantially influenced? *J. Med. Ethics* 22, 232–237 (1996).

43 Gallant MH, Beaulieu MC, Carnevale FA. Partnership: an analysis of the concept within the nurse-client relationship. *J. Adv. Nurs.* 40(2), 149–157 (2002).

44 Castro A, Ruiz E. The effects of nurse practitioner cultural competence on Latina patient satisfaction. *J. Am. Acad. Nurs. Pract.* 21(5), 278–286 (2009).

■ **Explores the relationship between degree of cultural competence in nurse practitioners and measures of patient satisfaction among Latino patients.**

45 Borg M, Karlsson B, Tondora J, Davidson L. Implementing person-centered care in psychiatric rehabilitation: what does this involve? *Israel J. Psychiat. Relat. Sci.* 46(2), 84–93 (2009).

46 Spiro HM. Visceral viewpoints. Constraint and consent – on being a patient and a subject. *N. Engl. J. Med.* 293(22), 1134–1135 (1975).

47 Hewlett S. Consent to clinical research – adequately voluntary or substantially influenced? *J. Med. Ethics* 22(4), 232–237 (1996).

48 Brock DW, Wartman SA. When competent patients make irrational choices. *N. Engl. J. Med.* 322(22), 1595–1599 (1990).

49 Bevan EG, Chee LC, Mcghee SM, McInnes GT. Patients' attitudes to participation in clinical trials. *Br. J. Clin. Pharmacol.* 35(2), 204–207 (1993).

50 Madsen S, Holm S, Riis P. Ethical aspects of clinical trials: the attitudes of the public and out-patients. *J. Intern. Med.* 245(6), 571–579 (1999).

51 Howell L, Kochhar K, Saywell R Jr *et al.* Use of herbal remedies by Hispanic patients: do they inform their physician? *J. Am. Board Fam. Med.* 19(6), 566–578 (2006).

52 Shelley BM, Sussman AL, Williams RL, Segal AR, Crabtree BF. 'They don't ask me so I don't tell them': patient–clinician communication about traditional, complementary, and alternative medicine. *Ann. Fam. Med.* 7(2), 139–147 (2009).

■ **Reports that although a great many Latino patients use herbal remedies they seldom report their use to their primary-care physician because they believe that if their physician knew they would be criticized or even humiliated.**

53 Haller CA. We should always ask our patients about unconventional treatments. *West J. Med.* 175(3), 164 (2001).

54 Anderson RM, Funnell MM. *The Art of Empowerment: Stories and STrategies for Diabetes Educators (2nd Edition)*. American Diabetes Association, Alexandria, VA, USA (2005).

55 Funnell MM, Nwankwo R, Gillard ML, Anderson RM, Tang TS. Implementing an empowerment-based diabetes self-management education program. *Diabet. Educ.* 31(1), 53–61 (2005).

56 Funnell MM, Anderson RM. Patient empowerment: a look back, a look ahead. *Diabetes Educ.* 29(3), 454–458 (2003).

57 Funnell MM, Anderson RM. Working toward the next generation of diabetes self-management education. *Am. J. Prevent. Med.* 22(Suppl. 4), S3–S5 (2002).

58 Anderson RM, Funnell MM, Nwankwo R, Gillard ML, Oh MS, Fitzgerald JT. Evaluation of a problem-based empowerment program for African Americans with diabetes. Results of a randomized controlled trial. *Ethn. Dis.* 15, 671–678 (2005).

59 Anderson RM, Funnell MM, Aikens JE *et al.* Evaluating the efficacy of an empowerment-based self-management consultant intervention: results of a two-year randomized controlled trial. *Ther. Patient Educ.* 1(1), 3–11 (2009).

60 Anderson RM, Funnell MM, Butler PM, Arnold MS, Fitzgerald JT, Feste CC. Patient empowerment. Results of a randomized controlled trial. *Diabetes Care* 18(7), 943–949 (1995).