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REDESIGNING REMUNERATION MODELS FOR PHYSICIAN SHIFTS: A BRAZILIAN HEALTHCARE NEGOTIATION CASE

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ABSTRACT

This article investigates a physician shift-coverage negotiation method at a general hospital operating in Rio de Janeiro's demanding healthcare market. The maternity department operates as the research unit because its uncontrolled shift changes threaten both patient safety and hospital operational performance. The research investigates how negotiation principles, including BATNA (Best Alternative to a Negotiated Agreement), ZOPA (Zone of Possible Agreement), and the positions-versus-interests analysis, help address workforce recruitment problems. The negotiation process used structured option-building to result in the adoption of variable remuneration through procedure-based payments. The intervention preserved its core elements, leading to higher doctor retention rates and demonstrating healthcare management negotiation techniques. The research results demonstrate that organizations need to adopt comprehensive systems that foster employee commitment during periods of market competition.

INTRODUCTION

Unlike routine administrative adjustments, negotiations over physician shift coverage involve continuous disruptions, resource limitations, and competing organizational priorities. Research by Saunders et al. (2009) highlights that management challenges, such as contractual ambiguities and operational gaps, frequently escalate into conflicts.

This research examines a single descriptive case from a Brazilian general hospital maternity department, in which uncovered shifts endangered both patient safety and hospital operational stability. The research shows that governance systems, together with interest-based dialogue and BATNA and ZOPA methods, allowed the development of new compensation systems that maintained physician participation.

Rubin and Brown (1975) defined negotiation as a joint effort between parties to reach mutual agreement (Dias, 2020). Dias (2020) applies Type II negotiation analysis to this case, using integrative methods that create shared value. The current studies about judicial reorganizations (Vidaletti & Dias, 2025) and business disputes (Bazerman & Moore, 1994; Delgado & Dias, 2025; Gasparini et al.,2025; Oliveira, Souza & Dias, 2025; Scheuer & Dias, 2025; Smejoff et al.,2025; Soliva & Dias, 2025; Valle, Trindade & Dias, 2025) reinforces the applicability of negotiation theory in diverse organizational settings. The current research builds on an established body of work to study physician shift coverage negotiations from an integrative negotiation perspective. We followed Dias (2020) negotiation classification, as depicted in Figure 1:

Figure 1: The Four-Type Negotiation Matrix
Source: Dias, 2020. Reprinted with permission.

METHODOLOGY

This study utilizes a single-case descriptive approach to examine bargaining techniques for physician shift coverage in a general hospital maternity department in Rio de Janeiro (Yin, 2018). The maternity service is the unit of analysis, and identified shifts posed operational hazards and competitive challenges. The descriptive method facilitated the systematic reconstruction of events, emphasizing negotiation dynamics over statistical generalization. Analytical approaches underscored the utilization of negotiation theory principles, such as BATNA (Best Alternative to a Negotiated Agreement), ZOPA (Zone of Possible Agreement), and the differentiation between positions and interests (Fisher & Ury, 1981; Lax & Sebenius, 1986; Dias, 2020).

LITERATURE REVIEW

Rubin and Brown (1975) define negotiation as a cooperative process intended to reach mutual consensus, a perspective further developed by Dias (2020) into a classification that distinguishes four types of approaches (see Figure 1), emphasizing interests beyond explicit positions, which has shown more effective in complex scenarios (Fisher & Ury, 1981; Lax & Sebenius, 1986).

Dias (2020) contends that Type II negotiation is especially relevant when integrative techniques create mutual value. Negotiation in organizational settings has been extensively examined as a process influenced by complexity, conflicting interests, and institutional limitations. Past studies show that gaps in contracts and unclear scope often lead to conflicts (Saunders et al., 2009). Similar dynamics are present in healthcare, where operational demands and manpower shortages complicate negotiations regarding resource distribution and physician participation. Empirical studies across various fields—from judicial reorganizations (Vidaletti & Dias, 2025) to corporate disputes (Bazerman & Moore, 1994; Delgado & Dias, 2025; Gasparini et al., 2025; Oliveira, Souza & Dias, 2025; Scheuer & Dias, 2025; Smejoff et al., 2025; Soliva & Dias, 2025; Valle et al., 2025)—illustrate the relevance of negotiation theory in organizational conflict resolution. This study uses the BATNA and ZOPA frameworks in the context of physician shift coverage, positioning healthcare negotiations within the broader field of integrative negotiation research. Research has studied negotiation in detail because it serves as a conflict-resolution tool that creates new value potential across various organizational environments. Rubin and Brown (1975) explain that negotiation functions as a collective method that helps different organizations reach mutual understanding. According to Dias (2020), who built on their research by developing negotiation categories and team-oriented negotiation systems, negotiation is a collective method that helps different organizations reach mutual understanding. The integrative negotiation method, which seeks to uncover hidden interests beyond stated positions, yields better results in complex situations (Fisher & Ury, 1981; Lax & Sebenius, 1986). The established framework applies specifically to healthcare because physician participation and shift management decisions affect both patient safety and hospital operational sustainability.

The process of distributive bargaining, which focuses solely on monetary adjustments, proves ineffective for resolving core interests in these situations. Organizations can develop sustainable competitive advantage by using integrative strategies that align their operational constraints with employees' career development needs. Dias (2020) identifies Type IV negotiation as the essential method that

organizations need to create shared value throughout their complex organizational systems. The hospital conducted this case study because it followed the established typology, which involved creating new physician compensation systems to maintain hospital staff while preventing major financial problems. The use of BATNA (Best Alternative to a Negotiated Agreement) and ZOPA (Zone of Possible Agreement) helped us achieve analytical clarity, supporting our decision-making within established financial limits. Empirical research across diverse domains reinforces the applicability of negotiation theory. The research by Vidaletti and Dias (2025) shows that judicial reorganizations enable agreements to endure financial challenges when organizations use integrative negotiation methods. Corporate dispute resolution research (Bazerman & Moore, 1994; Delgado & Dias, 2025; Gasparini et al.,2025; Oliveira, Souza & Dias, 2025; Scheuer & Dias, 2025; Smejoff et al.,2025; Soliva & Dias, 2025; Valle, Trindade & Dias, 2025) similarly shows that interest-based negotiation strategies outperform distributive approaches in maintaining long-term stability. The research findings show that negotiation frameworks work effectively across all sectors, including construction projects and healthcare institutions. The present study contributes to our understanding of how negotiation theory operates in healthcare management by analyzing physician shift-coverage negotiations. Organizations can resolve staffing disputes through integrative negotiation, which protects financial stability while providing patient care in competitive healthcare markets, according to the research.

BACKGROUND

In January 2026, the maternity department at a general hospital in western Rio de Janeiro welcomed a new leader. In last place, the team handled maternity care. The hospital has departments like obstetrics and gynecology. Obstetrics and gynecology have to work harder so the management sees them. Cardiology gets more attention because it brings in more money. The team had problems at first. The team did not set up the work well. Some staff did not feel ready. Sometimes the care went wrong. The team could not work well with other departments, like radiology and emergency services. The main problem was the medical shift schedule. There are two open shifts on Tuesday night. There is one open shift on Wednesday. There is one open shift on Thursday night. Sunday has two open shifts during the day. This uses a 15/15 schedule. This situation put the quality of care at risk. The situation gave the doctors more work. The situation made it easier for the institution to face problems. The issue escalated after the departure of two physicians who jointly managed 48-hour shifts. Existing challenges in finalizing schedules, especially on weekends, intensified; geographic location exacerbated recruitment issues, as commute and safety apprehensions diminished physician enthusiasm. The proximity to a significant rival, which provided enhanced compensation and benefits, intensified the issue, underscoring the need for organized bargaining to ensure coverage stability.

NEGOTIATION ANALYSIS

OPTIONS

Instead of simply requesting an increase in the fixed value of the shift, several possibilities were organized: (a) Adjustment of the fixed shift value, which has been frozen since 2020; (b) Implementation of payment per procedure performed during the shift; (c) Hybrid model, combining a small fixed adjustment with variable remuneration; (d) Specific bonus for the most critical shifts (Tuesday night, Wednesday daytime, Thursday night, and Sunday daytime under the 15/15 regime); (e) Expansion of indirect incentives, such as greater access to outpatient services. The presentation of these options broadened the scope of negotiation.

ALTERNATIVES (BATNA)

It was also made clear what alternatives existed in case no agreement was reached. From the hospital's perspective, the alternatives were: (a) Hiring a third-party company to cover shifts, at a higher cost and with less control (BATNA); (b) Reducing the schedule from two to one physician in certain time slots, assuming greater care risk. (c) Temporarily maintaining an incomplete schedule. These alternatives existed but were clearly inferior to a structured agreement. From the physicians' perspective, the BATNA was equally clear: (a) migrating to the competing hospital, which offered higher fixed monthly remuneration, (b) paid vacation, and (c) per-procedure payment. This strengthened their bargaining power.

ZOPA – ZONE OF POSSIBLE AGREEMENT

Upon closer analysis, the conflict was not simply about increasing or not increasing the fixed shift value. In practice, there was a possible interval for agreement. The minimum acceptable limit for physicians was tied to market competitiveness. Considering that four weekly shifts at the current hospital generated approximately R$ 4,544.00 per month (4 × R$ 1,136.00). At the same time, the competitor paid R$ 5,115.68 per month for weekday shifts; the monthly difference was R$ 571.68, excluding paid vacation and procedure-based remuneration. Therefore, for the shift to become attractive, potential monthly earnings must at least approach or exceed the R$ 5,115.68 threshold in the four-shift scenario. On the other hand, the hospital had clear limits. The outsourcing alternative costs R$1,656.00 per 12-hour shift, regardless of the day of the week. Considering four monthly shifts, this represented R$ 6,624.00 per

physician per month. Thus, any internal solution that kept monthly costs per physician below this value would still be economically more advantageous than full outsourcing. Accordingly, the zone of possible agreement was numerically delimited between the current approximate earnings of R$ 4,544.00 per month (four weekly shifts), and the institutional ceiling of R$ 6,624.00 per month (equivalent to outsourcing four shifts). Within this interval, the objective was to bring physician earnings closer to the competitive threshold of R$ 5,115.68 per month, without exceeding the ceiling of R$ 6,624.00 per physician per month. It was within this space that the option of payment per procedure fit. By creating a variable component, the hospital did not immediately raise the shift's fixed cost but allowed physicians' final earnings to exceed the R$ 571.68 monthly difference, depending on productivity, while remaining below the outsourcing cost. Thus, the ZOPA was not located in a direct adjustment of the fixed value but in the redesign of the remuneration model within the defined financial interval.

Deal and Lessons Learned

After meetings among the coordination team, medical board, and general management, it was decided to implement payment for procedures performed during the shift. The measure increased the attractiveness of the shifts and enabled coverage of most of the gaps. It was not a definitive solution for all schedules, but it stabilized the operation and gave us time to recruit new doctors. The initial position was "we need to increase the value of the shift". The real interest was to make the shift competitive and guarantee care coverage. The concept of BATNA was decisive. Knowing what our alternatives were and recognizing that the doctors had clear alternatives changed how we conducted the conversation. Building options before deciding was also essential. By expanding the possibilities, negotiation ceased to be purely distributive and began to incorporate more integrative elements. Finally, the delimitation of the ZOPA brought rationality to the process. When the boundaries became clearer, the solution began to seem feasible and less confrontational. After meetings among the coordination team, medical board, and general management, it was decided to implement payment for procedures performed during the shift. The measure increased the attractiveness of the shifts and enabled coverage of most of the gaps. It was not a definitive solution for all schedules, but it stabilized the operation and gave us time to recruit new doctors. If the parties had a new opportunity, he would structure the market data from the beginning and present the ZOPA already delimited, making the negotiation even more objective. It would also involve representatives of the clinical staff earlier in the construction of the options, increasing the sense of participation. I learned that negotiation is not just about discussing values; it is also about understanding interests, recognizing alternatives, and identifying where agreement is possible. Today I feel more prepared to conduct future negotiations with greater strategic clarity and less improvisation, especially on sensitive issues such as compensation and care coverage.

Discussion

The research example demonstrates how healthcare management professionals can apply negotiation theory to address situations in which physicians are considering leaving their practice because other hospitals offer better working conditions. Rubin and Brown (1975) define negotiation as a collaborative process aimed at reaching mutual agreement, and this case demonstrates how such collaboration can be structured even under significant constraints. The negotiation process advanced beyond basic fixed-remuneration requests by using integrative methods that focused on core interests, as described by Fisher and Ury (1981) and Lax and Sebenius (1986).

Identifying BATNA (Best Alternative to a Negotiated Agreement) during the negotiation process became essential. The hospital needed to pay more for less stable coverage through outsourcing, but physicians chose to leave for better compensation and benefits at their new practice. The evaluation process showed how each side presented itself during the talks, indicating that an immediate internal settlement was needed. Dias (2020) explains that Type II negotiations, which use integrative methods, produce the most common value in negotiation processes. The hospital developed this classification system to establish a payment structure that protected hospital financial stability while enabling doctors to compete effectively in their chosen medical field.

The negotiation process became more logical by defining the ZOPA (Zone of Possible Agreement). The team requested basic terms before setting specific financial boundaries, including their current earnings of R$ 4,544.00 and their maximum outsourcing budget of R$ 6,624.00. The payment system, which operated through medical procedures, allowed doctors to earn more than their competitors while the hospital spent less than it would have under outsourcing. The solution integrates all elements, as research indicates that organizations must develop new solutions to address operational problems and contractual breakdowns in intricate organizational systems (Saunders et al., 2009).

The study results align with previous investigations across different fields of research. The research by Vidaletti and Dias (2025) examined judicial reorganizations while Bazerman and Moore (1994) and Delgado and Dias (2025) and Gasparini et al. 2025; Oliveira, Souza & Dias, 2025; Scheuer & Dias, 2025; Smejoff et al.,2025; Soliva & Dias, 2025; Valle, Trindade & Dias, 2025) demonstrate that integrative negotiation strategies consistently outperform distributive approaches in sustaining long-term agreements. In healthcare, where workforce engagement directly impacts patient safety and institutional stability, the relevance of these strategies is amplified.

Healthcare organizations need to set financial targets that comply with the ethical standards medical staff must uphold during negotiations. The hospital applied negotiation theory principles, including BATNA, ZOPA, and integrative option-building, to achieve stability during major changes by retaining doctors and maintaining hospital services. Organizations can handle their healthcare disputes more effectively by using negotiation frameworks that lead to successful conflict resolution.

RESEARCH IMPLICATIONS

The research example demonstrates how healthcare management professionals can apply negotiation theory to address situations in which physicians are considering leaving their practice because other hospitals offer better working conditions. Rubin and Brown (1975) define negotiation as a collaborative process aimed at reaching mutual agreement, and this case demonstrates how such collaboration can be structured even under significant constraints. The negotiation process advanced beyond basic fixed-remuneration requests by using integrative methods that focused on core interests, as described by Fisher and Ury (1981) and Lax and Sebenius (1986).

This case demonstrates how such collaboration can be structured even under significant constraints. The negotiation process advanced beyond basic fixed-remuneration requests by implementing integrative strategies focused on Research Implications. The research example shows how negotiation theory applies directly to healthcare management operations. The hospital employed negotiation methods based on BATNA and ZOPA, as well as integrative negotiation, as described by Fisher & Ury (1981), Lax & Sebenius (1986), and Dias (2020), to preserve physician availability amid market competition. The research findings demonstrate that healthcare negotiation extends beyond monetary agreements, enabling organizations to develop solutions that meet both professional needs and business objectives. The research presents new evidence that builds on previous studies by applying negotiation principles from corporate and legal environments (Bazerman & Moore, 1994; Vidaletti & Dias, 2025) to demonstrate their effectiveness in hospital management for retaining staff and safeguarding patient safety.

LIMITATIONS OF THE STUDY

The research uses a single descriptive case study design, which provides a specific context but does not allow for generalization to all healthcare organizations. The unit of analysis was limited to one maternity department in Rio de Janeiro, which may not reflect broader national or international dynamics. The research data came from two sources: managerial documentation and direct observation of the situation. The details in the data could be influenced by the researchers' personal opinions. The research investigated how negotiation outcomes affect salary payments but did not examine other business factors, such as employee retention plans and government regulations.

CONCLUSION

Healthcare organizations can meet their staffing requirements by conducting staff negotiations that apply the BATNA and ZOPA theoretical models, as discussed in the case. The hospital achieved stability in its critical changes while keeping its doctors on staff and preventing costly external recruitment by transitioning from traditional bargaining to option development. The solution addressed a specific situation, yet the research results demonstrate that negotiation principles can be applied in healthcare organization management. The research shows that negotiation is a strategic method that links hospital sustainability initiatives with physician participation to protect patient welfare during resource shortages. The decision to implement payment for procedures during the shift brought concrete effects in the short term. Most of the critical shifts were covered, especially those on Tuesday night and Sunday, on a 15/15 basis, which were the most difficult to fill. There was still a specific need for scale adjustments in the first weeks, but the situation is no longer chronic and has become manageable. From the doctors' perspective, appreciation was relevant. Some professionals who were inclined to migrate to the competitor chose to stay, mainly because of the possibility of variable earnings. Although the model did not formally match the neighboring hospital's proposal, it made the shift competitive enough to reduce the immediate risk of dropout. The decision to implement payment for procedures during the shift brought concrete effects in the short term. Most of the critical shifts were covered, especially those on Tuesday night and Sunday, on a 15/15 basis, which were the most difficult to fill. There was still a specific need for scale adjustments in the first weeks, but the situation is no longer chronic and has become manageable. From the doctors' perspective, appreciation was relevant. Some professionals who were inclined to migrate to the competitor chose to stay, mainly because of the possibility of variable earnings. Although the model did not formally match the neighboring hospital's proposal, it made the shift competitive enough to reduce the immediate risk of dropout.

During the negotiation, it became clear that the medical director recognized the financial gap in the shift's value. However, there was an important structural limitation: a direct increase in the fixed amount could trigger a cascading effect across the hospital's other medical specialties, creating internal pressure for similar adjustments and affecting the institution's overall budget. In other words, the limitation was not only financial, but also political and organizational. In this context, the variable solution proved to be more viable precisely because it avoided this systemic effect. By not changing the formal fixed value of the shift, the decision reduced the risk of immediate repercussions in other medical areas, preserving the internal balance. Outsourcing was not necessary at that time. The cost of R$ 1,656.00 per shift was used as an upper limit in the negotiation, but did not need to be triggered. This preserved financial resources and kept clinical governance under institutional control. The negotiation, therefore, not only addressed the holes in the scale at that time but also showed that the problem was structural: the remuneration model was misaligned with the market and will require future review. The solution found was appropriate to the context, but made it clear that new negotiation cycles may still occur.

FUTURE RESEARCH

Future researchers are encouraged to examine how healthcare facilities in different locations use their negotiation approaches to identify patterns related to their specific systems. The research design of quantitative studies allows scientists to examine how physician maintenance rates, clinical outcomes, and healthcare facility expenses change over extended periods when different remuneration

systems are implemented. Research needs to examine how negotiation frameworks operate within current governance structures, including collective bargaining agreements and public health policies. The analysis of negotiation theory in healthcare environments would benefit from combining physician, administrative, and policymaker viewpoints.

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