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The Seven Crucial Conversations® for Healthcare

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The Seven Crucial Conversations for Healthcare

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NASA employs some of the smartest and most dedicated professionals in the world. Individually they are the cream of the crop in their various science, engineering, and administrative disciplines. Their collective achievements have dramatically expanded the boundaries of our knowledge of both our universe and our world. And yet in spite of their individual dedication and collective brilliance, on February 1, 2003, seven astronauts died—perhaps unnecessarily—when the *Columbia* Shuttle Mission STS-107 incinerated on reentry into the earth's atmosphere. The reason? A key contributor to the tragedy was a culture that "prevented effective communication of critical safety information and stifled professional differences of opinion."[1] People's inability to confront risky topics allowed risks to go unaddressed—contributing to the loss of seven lives.

Those who serve daily in U.S. hospitals could be described as similarly intelligent and dedicated. In the aptly titled report *To Err is Human*[2], the Institute of Medicine acknowledges both the individual dedication and collective contributions of those who give their all to improve and save the lives of patients in our healthcare institutions. And yet, as the report points out, each year hundreds of thousands of patients are brought to harm in the course of their healing because of fundamental problems in the collective behavior of these caring professionals. These problems are not unlike those that contributed to the loss of *Columbia*. For example, each year one in twenty in-patients at hospitals will be given a wrong medication, 3.5 million will get an infection from someone who didn't wash his or her hands or take other appropriate precautions[3], and 195,000 will die because of mistakes made while they're in the hospital.[4]

Hospitals are responding aggressively to this crisis with new technologies, quality-improvement systems, and methods of organizing. However, though the healthcare community is taking needed action on a number of fronts, there is a deeper problem that must be resolved before acceptable levels of improvement will be attainable.

As with NASA personnel, key problems that contribute to these tragic errors are often known far in advance. And yet few people talk about them. Every day, many healthcare workers stand next to colleagues and see them cut corners, make mistakes, or demonstrate serious incompetence. But only a small percentage speak up and discuss what they have seen—even though they're standing only a few feet away. As a result, problems go on for years—contributing to avoidable errors, high turnover, decreased morale, and reduced productivity. Just as the unwitting behavior of well-intended NASA personnel served to suppress key information that might have escalated risks, many healthcare workers tend to act in ways that allow risks and problems to remain unaddressed—sometimes for years.

> *A group of eight anesthesiologists agree a peer is dangerously incompetent, but they don't confront him. Instead, they go to great efforts to schedule surgeries for the sickest babies at times when he is not on duty. This problem has persisted for over five years.* (Focus Group of Physicians)

> *A group of nurses describe a peer as careless and inattentive. Instead of confronting her, they double check her work—sometimes running in to patient rooms to retake a blood pressure or redo a safety check. They've "worked around" this nurse's weaknesses for over a year. The nurses resent her, but never talk to her about their concerns. Nor do any of the doctors who also avoid and compensate for her.* (Focus Group of Nurses)

Past studies have indicated that more than 60 percent of medication errors are caused by mistakes in interpersonal communication. The Joint Commission on Accreditation of Healthcare Organizations suggests that communication is a top contributor to sentinel events.[5] This study builds on these findings by exploring the specific concerns people have a hard time communicating that may contribute to avoidable errors and other chronic problems in healthcare.

The study we report here suggests that there are seven *crucial conversations* that people in healthcare frequently fail to hold that likely add to unacceptable error rates. The nationwide study was conducted by VitalSmarts in partnership with the American Association of Critical-Care Nurses. This study suggests that improvement in these seven crucial conversations could not only contribute to significant reductions in errors, but also to improvements in quality of care, reduction in nursing turnover, and marked improvement in productivity.

In addition, we will offer healthcare leaders a simple method for measuring their current performance in these seven crucial conversations, as well as an action plan for making measurable improvement in this key competency.

The Study

Researchers conducted dozens of focus groups, interviews, and workplace observations, and then collected survey data from more than 1,700 respondents, including 1,143 nurses, 106 physicians, 266 clinical-care staff, and 175 administrators during 2004. Their research sites included thirteen urban, suburban, and rural hospitals from across the U.S. These included a mix of teaching, general, and pediatric hospitals. Although this is a modest sample, the findings fit together in a significant and compelling way.

The study identified the categories of conversations that are especially difficult and, at the same time, especially essential for people in healthcare to master. The study showed that the quality of these crucial conversations relates strongly with medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover. We grouped these concerns into seven areas: Broken Rules, Mistakes, Lack of Support, Incompetence, Poor Teamwork, Disrespect, and Micromanagement.

More than half of the healthcare workers surveyed in this study had occasionally witnessed broken rules, mistakes, lack of support, incompetence, poor teamwork, disrespect, and micromanagement. Many had seen some of their colleagues cutting corners, making mistakes, and demonstrating serious incompetence. However, even though they had these concerns, fewer than one in ten fully discussed their concerns with the coworker. Furthermore, most healthcare workers neither believe it's possible nor even their responsibility to call attention to these issues.

About half of respondents say the concerns have persisted for a year or more. And a significant number of those who have witnessed these persistent problems report injurious consequences. For example, one in five physicians say they have seen harm come to patients as a result of these concerns, and 23 percent of nurses say they are considering leaving their units because of these concerns.

On the positive side, this study shows that healthcare workers who are confident in their ability to raise these crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying. About 10 percent of the healthcare workers surveyed fall into this category. While additional confirming research is needed, the implication is that if more healthcare workers could learn to do what this influential 10 percent seem to be able to do systematically, the result would be significantly fewer errors, higher productivity, and lower turnover.

Prevalence of the Seven Most Crucial Concerns

Participants were asked to indicate the percentage of their coworkers with whom they had each of the seven crucial concerns. They had to indicate that at least 10 percent of their coworkers were in violation to be categorized as "seeing the concern." It is important to point out that respondents consistently report that the vast majority of healthcare workers *do not* exhibit the problems described below. And yet the vast majority of healthcare workers *do* see some number who not only exhibit the problems, but also continue to do so for long periods of time without being held accountable.

1. **Broken Rules:** 84 percent of physicians and 62 percent of nurses and other clinical-care providers see some number of their coworkers taking shortcuts that could be dangerous to patients. This concern was focused on a relatively small number of their colleagues. The median was 10 percent, meaning that they were comfortable with 90 percent of their colleagues' ability.

   "A phlebotomist in a neonatal unit would slip on her gloves and immediately tear the tip of the index finger off her glove, so she could feel the baby's vein better and wouldn't miss. I talked to her about it twice. Finally I said, 'If I ever see you tear the finger out of another glove I will write you up for a willful violation.' Now she follows the rules." (Nurse Manager)

2. **Mistakes:** 92 percent of physicians and 65 percent of nurses and other clinical-care providers work with some people who have trouble following directions; 88 percent of physicians and 48 percent of nurses and other clinical-care providers see some colleagues show poor clinical judgment when making assessments, doing triage, diagnosing, suggesting treatment, or getting help. Again, these respondents are pointing to a relatively small minority of their colleagues—the median was again just 10 percent.

   "Some docs can make incorrect orders. We let it slide—especially if it is a jerk . . . For example, one physician prescribed a drug that you should give three times a day, but he said to give it twice a day. I let it go, because it was just a pain pill. It wasn't going to make the child any sicker." (Pharmacist.)

3. **Lack of Support:** 53 percent of nurses and other clinical-care providers report that 10 percent or more of their colleagues are reluctant to help, impatient, or refuse to answer their questions. 83 percent have a teammate who complains when asked to pitch in and help. On the positive side, 76 percent say that half or more of their colleagues give them emotional support when they are down, and 64 percent say that half or more of their colleagues pick up a share of their work when they need help. It's clear that most people provide support. The problem is with a small minority who don't.

   "Some people here are burnt out. They've lost the excitement or have some personal issue in their life . . . People have to cover for them, pick up their slack. People get mad at them, isolate them, don't offer to help them, shy away from them. If they need extra help, they don't get it. They don't call or ask for it." (Nurse)

4. **Incompetence:** 81 percent of physicians and 53 percent of nurses and other clinical-care providers have concerns about the competency of some nurse or other clinical-care provider they work with; 68 percent of physicians and 34 percent of nurses and other clinical-care providers have concerns about the competency of at least one physician they work with.

   "There is a cardiologist who everybody feels is incompetent. He makes himself very accessible to general practitioners, so he gets a lot of referrals, but those of us who have to work with him—the thoracic surgeons, the anesthesiologists, the other cardiologists—would never put someone under his care." (Physician)

5. **Poor Teamwork:** 88 percent of nurses and other clinical-care providers have one or more teammate who gossips or is part of a clique that divides the team. 55 percent have a teammate who tries to look good at others' expense.

   "We have a nurse who is like your eccentric aunt—she's a bully. She makes unreasonable demands like, 'I won't take any more patients today.' She gets away with it. She's a very good nurse, but she's ornery and a bully. She doesn't do her fair share. It ticks all of us off. We've lost a couple of good nurses here because they were sick of putting up with her and our supervisor won't deal with her." (Nurse)

6. **Disrespect:** 77 percent of nurses and other clinical-care providers work with some who are condescending, insulting, or rude. 33 percent work with a few who are verbally abusive—yell, shout, swear, or name call.

   "A group of physicians went right into the patient's room without gowns or masks or gloves. This was a patient who was supposed to be in isolation. We didn't confront them because that cardio surgeon has a reputation. He belittles nurses by saying things like, 'Do they have any nurses on this unit who aren't stupid?' If you question him, he starts yelling, and turns it into a war." (Nurse)

7. **Micromanagement:** 52 percent of nurses and other clinical-care providers work with some number of people who abuse their authority—pull rank, bully, threaten, or force their point of view on them.

   "We have a charge nurse who . . . pages us to come to the desk so she can tell us what to do . . . She will come into the room where we have a sick patient and she'll take over . . . She'll say, 'Do it because I say so.' Sometimes when she bosses me around I feel less inclined to correct her when she's wrong about how to treat the child. I'm sure I've gone along with something I shouldn't have because I resent her. But basically, I've started looking at other hospitals for a job." (Nurse)

The Impact of these Crucial Conversations

Most healthcare respondents are happy in their careers and believe their organizations do good work. And yet most respondents report that a number of their colleagues create problems that are common, frequent, persistent, and dangerous. And, most important, the data show these problems are rarely addressed.

The study focused in detail on three of the seven crucial conversations: incompetence, poor teamwork, and disrespect. In these three areas the study mapped the frequency, duration, and impacts of people's concerns. It also measured whether and how these concerns were addressed.

Incompetence

The survey asked about a variety of competency issues, ranging from "poor clinical judgment" to "making decisions beyond their competency level" to "missing basic skills." Respondents indicated whether they had coworkers who are incompetent in these areas. Next, respondents were asked to think of the coworker with the worst competency problem, and to rate how often this person does something dangerous, how long the problem has gone on, and how the person's competency has impacted patient health and safety.

The data in tables 1-a and 1-b reveal the scope of the problem. Most healthcare workers have serious concerns about the competence of some of their coworkers. In fairness, a person's perceptions of another's competence can sometimes be just a difference of judgment—and nowhere more than in a field as complex and often ambiguous as healthcare. And yet the prevalence of the perceptions, along with strong anecdotal data from focus group interviews, suggest that real problems exist. Many cite a coworker who does something dangerous as often as every month. Nearly half report the problem has continued for a year or more. Some have witnessed the person causing harm to patients. And yet only a small percentage discuss their concerns with the person.

The data show it is much tougher to confront a physician than to confront a nurse or other clinical-care provider. Interestingly, the data also show physicians are about as unlikely to confront nurses and other clinical-care providers as they are to confront physicians, even though their clinical authority would seem to make it an easier discussion.

Nurses and Other Clinical Care Providers' Concerns about Incompetence		
53% are concerned about a peer's competence. 12% have spoken with this peer and shared their full concerns.	This peer does something dangerous at least once a month.	27%
	The problem with this peer has gone on for a year or more.	48%
	A patient has been harmed by this person's actions during the last year.	7%
34% are concerned about a physician's competence. Less than 1% have spoken with this physician and shared their full concerns.	This physician does something dangerous at least once a month.	19%
	The problem with this physician has gone on for a year or more.	54%
	A patient has been harmed by this physician's actions during the last year.	8%

Table 1-a

Physicians' Concerns about Incompetence		
81% are concerned about a nurse's or other clinical-care provider's competence. 8% have spoken with this person and shared their full concerns.	This person does something dangerous at least once a month.	15%
	The problem with this person has gone on for a year or more.	46%
	A patient has been harmed by this person's actions during the last year.	9%
68% are concerned about a physician's competence. Less than 1% have spoken with this physician and shared their full concerns.	This physician does something dangerous at least once a month.	21%
	The problem with this physician has gone on for a year or more.	66%
	A patient has been harmed by this physician's actions during the last year.	19%

Table 1-b

Poor Teamwork

The survey examined a variety of teamwork concerns, ranging from "gossiping" to "making themselves look good at your expense" to "not doing their fair share of the work." Respondents indicated whether they had coworkers who demonstrated poor teamwork in these areas. Next, respondents were asked to think of the coworker whose poor teamwork has the most negative impact, and to rate how often this person does something that undermines the team, how long the problem has gone on, and how the person's poor teamwork has impacted patient care and employee morale.

The data in Table 2 show a widespread problem. Three-quarters of the healthcare workers surveyed are concerned about a teamwork issue, and more than two-thirds say this problem has gone on for over a year. A smaller—yet significant—number (one-fifth) say the teamwork issue is so severe they can't trust that patients are getting the right level of care, and even more are seriously considering leaving their jobs because of the teamwork issue. And yet relatively few ever discuss their concerns with the person involved.

Nurses and Other Clinical Care Providers' Concerns about Poor Teamwork		
75% are concerned about a peer's poor teamwork.	This peer does something that undercuts the team at least once a month.	61%
	The problem with this peer has gone on for a year or more.	69%
16% have spoken with this peer and shared their full concerns.	Because of this teamwork issue, the respondent can't trust that patients in their area are receiving the right level of care.	22%
	Because of this teamwork issue, the respondent is seriously considering leaving the unit or the hospital.	23%

Table 2

Disrespect

The survey asked about disrespectful and abusive behavior, ranging from "verbal abuse" to "condescending, insulting, or rude" to "bullying and threatening." Respondents indicated whether they worked with people who were abusive toward them in these ways. Next, respondents were asked to think of the person whose abuse has the most negative impact, and to rate how often this person is disrespectful or abusive toward them, and how long the problem has gone on.

The data in Table 3 show that three-quarters of the healthcare workers surveyed experience some level of disrespect. For many, the treatment is frequent and long-standing. The correlations show that the more frequent the behavior and the longer it has gone on, the greater the workers' intent to quit their jobs. In fact, these correlations are so strong (correlations where r>.1 are meaningful—here we find r=.424, which is impressive) that disrespectful behavior is suggested to be a primary cause of people's desire to quit. Discussing their concerns with the person who is responsible for the abuse is almost out of the question.

Nurses and Other Clinical Care Providers' Concerns about Disrespect and Abuse		
77% are concerned about disrespect they experience.	This person is disrespectful or abusive toward them in at least a quarter of their interactions.	28%
	The behavior has gone on for a year or more.	44%
7% have spoken with this peer and shared their full concerns.	Correlation between the frequency of mistreatment and intent to quit their job.	$r = .424$, $p < .001$
	Correlation between the duration of abuse and intent to quit their job.	$r = .190$, $p < .001$

Why Don't People Speak Up and Share Their Full Concerns?

The obvious reason is that confronting people is difficult. In fact, most respondents to the survey indicated it was between difficult and impossible to confront people in these crucial situations. People's lack of ability, belief that it is "not their job," and low confidence that it will do any good to have the conversation are the three primary obstacles to direct communication.

When the Concern Is…	Percentage Saying It Is Difficult to Impossible to Confront the Person
Incompetence	56% of Physicians 72% of Nurses and other Clinical-Care Providers
Poor Teamwork	78% of Nurses and other Clinical-Care Providers
Disrespect or Abuse	59% of Nurses and other Clinical-Care Providers

Table 4

Other obstacles include time and fear of retaliation. The survey asked respondents to indicate the reasons they didn't confront people when they had these important concerns. The reasons they selected were similar for each concern, with the most common reasons being: "There wasn't a time or opportunity," "It's not my role," "I've seen them get angry," and "I thought they would retaliate." People don't want to make others angry or undercut their working relationships, so they leave difficult discussions to others or to another time, and never get back to the person.

However, some people don't remain silent about the problems they see. They talk about them with others. Depending on the nature of the problem, a quarter to half of the respondents discussed the problem with coworkers or with the person's manager. In interviews, participants suggested that the purpose for discussing these problems with coworkers is not to solve problems. Instead, it's to work around them, warn others about them, and blow off steam. The comments below, taken from focus groups, illustrate these workarounds, warnings, and venting sessions.

> *"We all know who I'm talking about. She has bad habits, or is missing good ones. She gets busy and leaves the rails down on an infant bed or the door open on an incubator. We all check on her patients just to make sure about things."* (Nurse)

> *"People give you the word. A nurse will call from surgery and say, 'He's in a mood.' If something goes wrong in surgery, he'll come in yelling at people. You are just waiting for your turn."* (Nurse)

> *"She can't be trusted with cases. She can give meds, but she won't ever get it. She's been there for seven months. This nurse would do fine in a doctor's office, but won't make it in the hospital. The other nurses all agree."* (Nurse)

Most respondents also say going to the person's manager creates problems.

> *"I'm embarrassed. I saw a nurse cutting corners and instead of talking to her I talked to her boss. Here's the situation. I used to be this nurse's boss, but now she's training me and we are peers. I should have gone to her, but I was concerned about our relationship and I went to her boss instead. It was a bad move."* (Nurse Practitioner)

The data suggest that going to the person's manager is, indeed, a bad move. Although managers are somewhat more likely than employees to confront the person and fully discuss the problem, they are still very unlikely to do so. Taking a concern to a manager was often a dead end.

When the Concern Is	Percentage of Non-Supervisory Employees Who Confront the Person	Percentage of Supervisors Who Confront the Person
Competence of a Nurse or other Clinical-Care Provider	3%	16%
Competence of a Physician	Less than 1%	Less than 1%
Poor Teamwork	5%	9%
Disrespect or Abuse	2%	5%

Table 5

People Who Do Step Up to these Crucial Conversations

Within each hospital there is a fascinating minority, 5–15 percent of healthcare workers, depending on the issue, who step up to these crucial conversations. They work in the same units or departments as the 85–95 percent of their coworkers who don't feel able to speak up. Are they crazy? Are they destroyed by the unsafe environment? No; these people prove that it's possible to discuss serious concerns in almost any environment and succeed.

The significant correlations in Table 6 show that people who are confident in their ability to have crucial conversations achieve positive outcomes for their patients, for the hospital, and for themselves. This is counterintuitive. Most of those who don't speak up believe that to do so would lead to disaster. The opposite seems to be the case for this critical minority of interpersonally skilled individuals. Again, the correlations of from .2 up to .465 suggest that these peoples' ability to deal with tough interpersonal challenges is highly related to all of the outcomes described. The "p<.001" means that the odds that this strong relationship is due to chance is less than 1 in 1000.

Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is Incompetence	Observe better patient outcomes (Spearman correlation = -.336, p < .001)
	Are more satisfied with their workplace (Spearman correlation = -.267, p < .001)
	Exhibit more discretionary effort[6]—work beyond the minimum required (Spearman correlation = -.240, p < .001)
	Intend to stay in their unit and hospital (Spearman correlation = -.335, p < .001)
Physicians who are confident in their ability to confront people when the concern is Incompetence	Observe better patient outcomes (Spearman correlation = -.307, p < .001)
	Are more satisfied with their workplace (Spearman correlation = -.309, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.263, p < .001)
Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is Poor Teamwork	Observe better patient care (Spearman correlation = -.310, p < .001)
	Have higher morale (Spearman correlation = -.465, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.297, p < .001)
	Intend to stay in their unit and hospital (Spearman correlation = -.460, p < .001)
Nurses and other clinical-care providers who are confident in their ability to confront people when the concern is disrespect or abuse	Are more satisfied with their workplace (Spearman correlation = -.271, p < .001)
	Exhibit more discretionary effort—work beyond the minimum required (Spearman correlation = -.203, p < .001)
	Intend to keep their job (Spearman correlation = -.258, p < .001)

Table 6

These correlations make sense. People who feel able to confront and resolve the problems they see, take action, and improve the environment for everyone. Consider the two examples below. The first involves a physician who wasn't able to confront a peer.

> *"One surgeon actually left because of another's lousy work ethic. You'd call him at one in the morning, and he'd say, 'It can wait till morning.' The best member of his practice quit over it. No one ever made him shape up or confronted him over it. Docs would talk about it, but not to him."* (Physician)

When problems are allowed to fester, morale and productivity suffer, and patients are put at risk. Below is a contrasting example from a physician who is comfortable confronting his peer.

> *"I have a guy in my practice who is (acting in an inappropriate way) . . . It meant that his other partners and I would have to work more nights. I spoke to him. It wasn't easy but he agreed to change."* (Physician)

People who are able to speak up and address the problems they see make a positive difference. This finding isn't a big surprise. The surprise is how few healthcare workers speak up. The confident physician in the example above represents less than one in a hundred of the physicians in our sample. The other 99 percent live with their concerns and the bad outcomes they see around them.

Conclusions

The majority of the healthcare workers in this study have serious concerns about someone they work next to. Some share these concerns with coworkers and managers, but rarely speak directly to the people they are concerned about. Few of their coworkers and managers approach these people either, so the problems continue with a high frequency and for a long time.

It is critical for hospitals to create cultures of safety, where healthcare workers are able to candidly approach each other about their concerns. The added benefits in productivity improvement, reduction in nursing turnover and physician cooperation make improvement in this core competence an overwhelmingly high-leverage objective. However, it would be dangerous to conclude that the responsibility for breaking this pervasive culture of silence depends solely on making it *safer* to speak up. There are those in every hospital who are *already* speaking up, and they are not suffering for their outspokenness. Although they are only 5–15 percent of the total, they are the most effective, satisfied, and committed in the organization.

Hospitals need to learn from this skilled minority. VitalSmarts has spent 10,000 hours observing these *opinion leaders* and can recommend a series of steps for spreading their capabilities across a hospital.

Recommendations

The medical and business leaders of a hospital need to make improving crucial conversations one of their top two or three priorities for at least a year. The reluctance to confront is so deeply rooted in the healthcare culture that it will take this level of attention to create lasting improvements. The American Association of Critical-Care Nurses points out that lasting change in challenging interpersonal communication practices like these will require the combined commitment of nurses and healthcare professionals as well as healthcare organizations.[7]

Enabling crucial conversations may involve a variety of interventions, depending on the obstacles and inertia present in a hospital. Here we will focus on four steps that have provided rapid payoffs in many organizations.

Establish a Baseline and a Target for Improvement

The fundamental principle of organizational attention is: If you don't measure it you don't care about it. Survey the hospital to establish a baseline measure of the seven crucial conversations, and set a clear target for improvement.[8] A public goal for 25 percent improvement in a one-year period is achievable, and will concentrate attention on the issue. Update the baseline at least four times a year so people can be rewarded and held accountable for progress.

Conduct Focus-Group Interviews

Form interview teams that include top administrators and key physicians, and have these interview teams lead focus groups. It is important to have leaders, not staff, conduct these interviews. Leaders need to hear about the problems and their causes directly, and they need to demonstrate their willingness to listen.

The purpose of these interviews is to learn about the obstacles preventing crucial conversations. The most common obstacle you will hear is "safety;" people feel it is unsafe to confront.[9] Leaders need to take this safety concern to heart, because it is a criticism aimed at them. The interviews should solicit specific feedback about the kinds of behaviors and experiences people have that lead them to conclude they should *not* step up to these crucial conversations—or vice versa in areas where the conversations are happening.

> *"Everybody knows the cardiac surgeons can do whatever they want because they bring in a lot of dollars. I was warned not to confront them."* (Nurse)

If a cardiac surgeon is preventing nurses from confronting him or her, it is only because a manager or another physician is permitting it. These focus groups are an opportunity for leaders to learn about their role in allowing problems to continue.

Focus on Problem Areas

Use the baseline survey to focus your efforts. The survey will show you where conversations aren't happening or aren't happening well. Often, these are high-stress, high-impact areas such as the emergency room, operating rooms, and intensive care units. Focus on the intersection of "poor conversations" and "high impact."

Form teams within these problem areas, and have medical and administrative leaders participate. These teams should identify key obstacles and develop solutions to test.

Implement Training

A handful of the people in your hospital are already speaking up and resolving the problems they see around them. Training can be a powerful way to help others speak up, but its success is far from guaranteed. Below are the most critical elements in determining whether training will result in significant improvements.

- **Leaders teach.** Leaders need to conduct the training. Research shows that line managers, even those selected for their *poor* teaching abilities, achieve greater improvements than highly rated professional trainers.[10] In addition, having a leader teach a set of skills guarantees he or she will master them, and goes a long way toward ensuring he or she will "walk the talk" and model the skills.

- **Quality Materials.** The training must employ an effective instructional design. Participants need to be able to understand the concepts and master the behaviors. The skills taught should be valid in the highly emotional and risky confrontations we're asking people to step up to. Generic "communication" training will not suffice as the rules and challenges change when these seven emotionally and politically risky topics emerge. In addition, the training activities need to include emotionally compelling experiences that cause participants to examine themselves and recognize the need to change.[11]

- **Spaced learning.** Smaller chunks spaced a week or two apart are far better than longer, more intensive chunks. Two-hour or four-hour workshops avoid the cognitive overload so common in many training programs, and spaced learning allows people to apply and test the skills between sessions.

- **Sustained attention.** Some training interventions seem like a race to the finish—as if the goal were to get everyone through the course as quickly as possible. In fact, sustaining a skill-building effort over time is more important than "finishing" it on deadline. Unless people stay in the learning process for four to six months, it won't penetrate to their daily experience.

- **Relevant.** Obviously the content of the training must relate directly to risky situations people need to confront. Generic training in listening and feedback won't help participants handle the tough situations measured in our

study. Practices built into the training should focus on the specific crucial conversations the individuals involved need to master.

The problem described in this study is severe. 1) People see others make mistakes, violate rules, or demonstrate dangerous levels of incompetence 2) repeatedly 3) over long periods of time 4) in ways that hurt patient safety and employee morale 5) but they don't speak up and 6) the critical variable that determines whether they break this chain by speaking up is their confidence in their ability to confront.

These results give hospitals a powerful tool for improving patient safety and employee performance. The inability to speak up is an information bottleneck. Finding and removing the bottlenecks will release a cascade of benefits. Leaders can begin this process immediately, and achieve rapid and substantial progress.

About the Sponsors

VitalSmarts

A global leader in organizational performance and leadership, VitalSmarts provides training and consulting services to thousands of organizations, including more than 300 of the Fortune 500. For more than twenty-five years, the company principals have researched methods for bringing about systematic and lasting change. *Crucial Conversations*®, (including *The New York Times* bestselling book of the same title—McGraw-Hill 2002) delivers a set of influence tools that vitalize companies, strengthen teams, improve communities, and enrich relationships. Borrowing from more than twenty-five years of research, VitalSmarts introduces its newest *Wall Street Journal* and *New York Times* bestselling title, *Crucial Confrontations* (McGraw-Hill 2004), as well as a new set of training tools that teach organizations, teams, and individuals to effectively deal with violated expectations in a way that solves the problem at hand and strengthens the relationship in the process. VitalSmarts also offers other services including keynote speaking, on-site consulting, customized development, and executive mastery retreats.

AACN

The American Association of Critical-Care Nurses (AACN) is the world's largest specialty nursing organization. Representing the interests of more than 400,000 nurses who care for critically ill patients, AACN is dedicated to creating a healthcare system driven by the needs of patients and their families, where critical-care nurses make their optimal contribution.

AACN defines critical-care nursing as that specialty within nursing that deals with human responses to life-threatening health problems. The purpose of AACN is to promote the health and welfare of those experiencing critical illness or injury by advancing the art and science of critical care nursing and promoting environments that facilitate comprehensive professional nursing practice.

Endnotes

[1] Columbia Accident Investigation Board Report Volume 1 (August 2003) 9.

[2] L. Kohn, J. Corrigan, M. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, DC: National Academy Press, 2000) 127.

[3] Richard P. Wenzel and Michael B. Edmond, "The Impact of Hospital-Acquired Bloodstream Infections," Emerging Infectious Diseases 7, no. 2 (March–April 2001)

[4] HealthGrades Quality Study: *Patient Safety in American Hospitals*, (HealthGrades, Inc., July, 2004).

[5] Joint Commission on Accreditation of Healthcare Organizations, *Root Causes of Medication Errors 1995-2003.* http://www.jcaho.org/accredited+organizations/ambulatory+care/sentinel+events/rc+of+medication+errors.htm

[6] "Discretionary effort" is a concept first introduced by Daniel Yankelovich in 1983 (Yankelovich and Immerwahr, *Putting the Work Ethic to Work,* Public Agenda Foundation). It is the engine of productivity in any knowledge-intensive organization. Discretionary effort is the gap between the least amount a worker can put in without being sanctioned or fired and the most they could put in if they chose to. In many professions this "discretionary effort" can account for productivity improvements of 100–500 percent when an employee chooses to offer it.

[7] *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence* (American Association of Critical Care Nurses: 2005) 40.

[8] A downloadable survey of these seven crucial conversations is available at www.silencekills.com along with usage requirements.

[9] A downloadable script and suggested structure for these interviews is available at www.silencekills.com.

[10] VitalSmarts research on using leaders as teachers.

[11] For information on VitalSmarts' approach to Crucial Conversations, www.silencekills.com.