Silence Kills

The Seven Crucial Conversations in Healthcare

David Maxfield, Joseph Grenny, Ron McMillan, Kerry Patterson, Al Switzler

All too often, well-intentioned people in healthcare institutions choose not to speak up when they're concerned with behavior, decisions, or actions of a colleague. For example,

- A pharmacist receives a prescription that is clearly incorrect but fills it anyway because the doctor has been hostile when challenged in the past.
- A nurse quits reminding a colleague to put up the safety rails on a child's bed because she decides it's not her job to deal with her.
- An administrator is reluctant to drive quality improvements in the hospital because some doctors have been uncooperative with past initiatives.

Past studies have indicated that more than 60 percent of medication errors are caused by mistakes in interpersonal communication (JCAHO). This new 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. This study is the first to attempt to link people's ability to discuss emotionally and politically risky topics in a healthcare setting with key results like patient safety, quality of care, and nursing turnover, among others.

The study finds that seven categories of conversations are especially difficult and, at the same time, appear to be especially essential for people in healthcare to master—including:

1. Broken rules
2. Mistakes
3. Lack of support
4. Incompetence
5. Poor teamwork
6. Disrespect
7. Micromanagement

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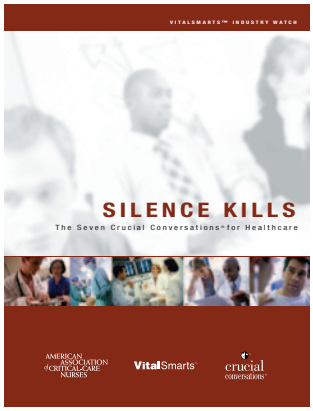

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A majority of healthcare workers regularly see some of their colleagues break rules, make mistakes, fail to offer support, or appear critically incompetent. And yet less than one in ten say anything about it. This study explored the frequency with which people experience these kinds of concerns and the consequences of their failure to speak up when they do.

Researchers conducted dozens of focus groups, interviews, and workplace observations, and then collected survey data from more than 1,700 nurses, physicians, clinical-care staff, and administrators during 2004. Research sites included thirteen urban, suburban, and rural hospitals from across the U.S. Although this is a relatively small sample and includes only one hundred physicians, the findings paint a significant and compelling picture.

More than half of the healthcare workers surveyed have witnessed a small percentage of their coworkers break rules, make mistakes, fail to support, demonstrate incompetence, show poor teamwork, disrespect them, and micromanage. Many have seen colleagues cutting corners, making mistakes, and demonstrating incompetence.

About half of respondents said 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 said they have seen harm come to patients as a result of these concerns, and 23 percent of nurses said they are considering leaving their units because of these concerns. With 195,000 people dying each year in U.S. hospitals because of medical mistakes, this study suggests that creating a culture where healthcare workers speak up *before* problems occur is a vital part of the solution.

On the positive side, this study shows that the 10 percent of 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 in their jobs. The finding suggests that improving people's ability to candidly discuss these concerns could be a key variable in improving results and saving lives in healthcare. 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 significant reductions in errors, higher productivity, and lower turnover.

The authors conclude it is critical for hospitals to create cultures of safety, where healthcare workers are able to candidly approach each other about their concerns. 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. In fact, they are the most effective, satisfied, and committed in the organization. The authors provide a series of recommendations for actions leaders can take to improve people's ability to hold these crucial conversations.