

Dialogue Heals

The Seven Crucial Conversations[®] for the Healthcare Professional



By David Maxfield Joseph Grenny Kerry Patterson Ron McMillan Al Switzler

Discussion topics and recommendations based on the study *Silence Kills: The Seven Crucial Conversations for Healthcare*

About *Dialogue Heals*

Dialogue Heals introduces the groundbreaking study *Silence Kills: The Seven Crucial Conversations for Healthcare* (VitalSmarts 2005) along with recommendations based on best-practice skills learned over the past twenty-five years by spending 25,000 hours watching those who skillfully speak up during crucial conversations. This influential minority of people hold the key to speaking up in a way that gets results without provoking defensiveness.

Each section of this booklet describes an opportunity to step up to a crucial conversation and offers advice for how to step up effectively. This is an introductory tool only.

Group Discussions

As a study guide, *Dialogue Heals* may be used to facilitate group discussion and awareness. To achieve immediate results, do the following:

- Organize a study group of up to ten people.
- Download and review the findings in *Silence Kills: The Seven Crucial Conversations for Healthcare* (visit www.dialogueheals.com for details).
- Read and discuss the scenarios in *Dialogue Heals*. Discussion questions are provided.
- Discuss how you can take immediate action in your team or organization.

3 Ways to Take Action

Visit www.dialogueheals.com to begin building a culture of safety and quality in your organization. Take advantage of these special offers:



1 For You

- Access free resources to help you learn Crucial Conversations skills—including a weekly e-mail newsletter, video examples, Web seminars, and more.
- Receive discount offers on books, audio CDs, training aids, public workshops, and trainer certification.
- Use *Dialogue Heals* to discuss key concepts with a coworker, friend, or spouse.

2 For Your Teams

- Use *Dialogue Heals* to lead a discussion group with your team and begin the process of change.
- Encourage teammates to sign up for free resources and continue your group discussion.

3 For Your Organization

- Introduce *Dialogue Heals* to the training professionals or executives in your organization.
- Encourage line managers, meeting organizers, and executives to build a culture of safety and quality by exploring the concepts of *Dialogue Heals* and taking steps toward a solution.

Create a Culture of Safety and Quality!

Visit www.dialogueheals.com 

Overview

Dialogue Heals is based on our recent groundbreaking study, *Silence Kills: The Seven Crucial Conversations for Healthcare*. This study uncovers communication breakdowns in healthcare that contribute to avoidable errors and chronic problems. As a learning tool, *Dialogue Heals* introduces powerful skills that can improve communication for individuals, teams, and organizations—skills designed to create immediate and lasting change. As you review *Dialogue Heals* and discuss it with others, you are taking the first steps toward creating a culture of safety and quality.

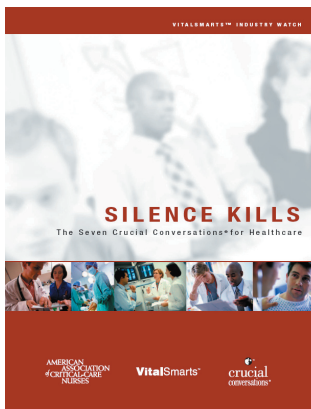
About *Silence Kills*

A 2005 Study conducted by VitalSmarts and the American Association of Critical-Care Nurses indicated that there are seven crucial conversations healthcare professionals consistently fail to hold. And more importantly, it demonstrated that how individuals handle the issues surrounding these seven crucial conversations is strongly related to medical errors, quality of care, nursing and physician satisfaction, and productivity.

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

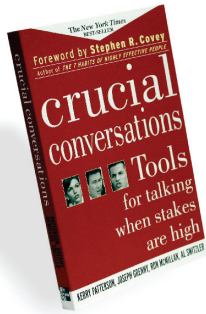
- A pharmacist receives a prescription that is clearly incorrect but fills it anyway because the doctor has been hostile when challenged in the past. He says nothing to the doctor about the effect of his hostile behavior.
- A nurse quits reminding a colleague to put up the safety rails on a child's bed because she decides it's not her job to keep dealing with this colleague.
- A group of physicians avoid putting their patients under the care of a cardiologist because they think he is incompetent—but say nothing about their concerns in a way that could lead to change. The cardiologist concludes it's all “politics.”
- An administrator is reluctant to drive quality improvements in the hospital because some doctors have been uncooperative with past initiatives. So when she does drive the new initiative, she does so with as little physician involvement as possible—provoking even more resistance without ever telling the physicians why she's reluctant to involve them.

Past studies have indicated that more than 60 percent of medication errors are caused by mistakes in interpersonal communication (JCAHO)¹. The *Silence Kills* 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

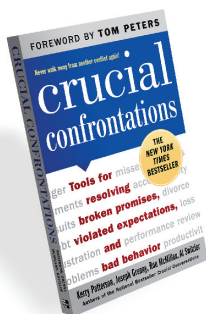


The full study,
*Silence Kills: The Seven
Crucial Conversations for
Healthcare*, may be
downloaded at
www.silencekills.com.

Next Steps



Help yourself, your team, or your entire organization to better handle the tough issues you face every day with two bestselling books: *Crucial Conversations: Tools for Talking When Stakes are High* (McGraw-Hill 2002) and *Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior* (McGraw-Hill 2004). Useful cross-references are made to both books throughout this guide.



Also, visit www.crucialskills.com to enjoy free resources (video clips, newsletters, self-scoring assessments) and more.

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. Lack of support
3. Mistakes
4. Incompetence
5. Poor teamwork
6. Disrespect
7. Micromanagement

These seven topics describe concerns people in healthcare face consistently—a majority of healthcare workers regularly see some of their colleagues break rules, make mistakes, fail to offer support, or appear critically incompetent. 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.

The most alarming finding of the study was that only one in ten healthcare professionals today actually speak up when facing these kinds of concerns. Far fewer speak up if the concern is with a physician. Their failure to speak up is highly related to all of the outcomes described previously (lower quality, lower morale, higher intention to quit, lower productivity, etc.)

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.

“I have learned that great healthcare can only be delivered if the caregiver is a skilled communicator as well as a skilled healer. At the heart of our ability to heal is our capacity to challenge anyone at any time about patient-related issues.”

- Peggy Troy, President, LeBonheur Children's Medical Center

Crucial Conversation #1

Broken Rules

Question: I'm a nurse. A fellow nurse in our neonatal unit regularly slips on her gloves and immediately tears the tip of the index finger off her glove, so she can feel the baby's vein better and won't miss with the IV. This violates infection standards and puts the baby at risk. I've spoken to her before about this once and she's still doing it. What now?

Answer: The first mistake people in this situation tend to make is that they hold the wrong conversation. For instance, this nurse might be tempted to talk to her colleague about violating infection standards—when this is not the real problem she is complaining about. The first time she spoke to her colleague, that was the concern. Clipping the finger off her glove put the baby at risk by exposing it to germs that do not belong in a neonatal unit.

Common examples of broken rules people need to learn to confront include:

- Not washing or sanitizing hands sufficiently
- Not gowning up, or skipping some other infection-control procedure
- Not changing gloves when appropriate
- Failing to check armbands
- Not performing safety checks
- Using abbreviations
- Not getting required approval before acting
- Violating policies on storing or dispensing medications

But as we said, in this instance the original problem is no longer the right problem to discuss. The problem the second time is not a single instance of violating standards, but a pattern of violating them in spite of being reminded. This nurse needs to now discuss her concern that in spite of a reminder the violation is still taking place. That's a far different conversation.

Here's a very powerful principle of Crucial Conversations: *If you ever have the same conversation twice, you're having the wrong conversation.*

Learn to notice what the *right* problem is—whether content (the first instance of concern—the immediate pain or problem you face); pattern (a series of violations despite reminders); or relationship (concerns about mistrust, incompetence, or disrespect).

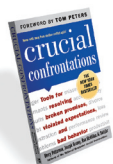
Now, this advice applies in an interesting way in the current situation. While the underlying problem you need to discuss is the *pattern*, the urgency of stopping a potential infection event overrides that concern. Your first responsibility is to immediately speak up about the *content issue—the immediate violation*. For example, you might try:

“Excuse me—you've clipped the finger out of your glove. Please stop what you're doing and put on a full glove.”

Once the incident is resolved, you need to have the pattern conversation. In this case, you may want to begin with the following:

“Twice in the past month I've tried to remind you about infection standards in the neonatal unit. This is now the third time you've clipped the finger out of your glove that I've seen. This is clearly a pattern and you're putting me in a position of either needing to escalate with our boss or become part of the problem by looking the other way. How do you see it?”

Discuss: How can holding the right conversation help our team in a situation we currently face?



Read Chapter 1, “Choose WHAT and IF,” of *Crucial Confrontations*:

Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior

Crucial Conversation #2

Lack of Support

Question: 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, talk about them behind their backs—and yet they continue to do less than their share. Even our nurse manager isn't dealing with them—so what am *I* supposed to do?

Answer: We often shy away from crucial conversations because we can't conceive of why someone would want to hear what we have to say. “Why,” for example, “would a poor-performing teammate want to hear my complaints about him or her?” The only thing we can imagine is our teammate becoming defensive and then resenting us even more in the future for having attempted the crucial conversation.

While this way of thinking about crucial conversations is typical, it is also fundamentally flawed. People don't become defensive because you have a hard message to deliver. They become defensive because *they don't feel safe* hearing the hard message from you.

One of the most important principles of Crucial Conversations is *Make It Safe*. If you can learn to create enough safety, people—regardless of their level or position—will let you say almost anything to them. This is true of doctors, your supervisor, your peers—anyone. People *want* to hear the truth if it's delivered safely. What they don't want is “brutal” honesty.

So, how do you create safety? During the first thirty seconds of a crucial conversation, you must help the other person know:

1. You care about *his or her best interests*.
2. You care about and respect *him or her*.

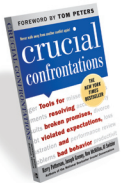
We typically fail in creating safety because, to be honest, we don't care about the other person's interests and we don't respect him or her. In brief, the problem is not that we lack skill, it's that we're selfish. We are so absorbed with how the problem is affecting us that we give no thought to how it's affecting others. Thus, when we speak up, they sense that we are there for our own selfish interests and they feel unsafe and become defensive. Defensiveness shows up as silence (withdrawing, avoiding) and violence (abusive language, pulling rank, turning the tables with accusations). If you come to realize that defensiveness is a “safety problem,” you become far more effective at diffusing it—and even avoiding it.

How could you create safety in approaching your peer about poor teamwork? Here's a sample:

“May I talk with you about a bit of a concern I've got? My reason for bringing it up is that I know you've felt some frustration about people isolating you, and even talking about you at times. I think I know why that's happening and I'd like to help. If I could share this concern with you I think we could find a way to solve it and make things work much better here for you and me both. Would that be all right?”

While this may not be the perfect script for all occasions, it's an example of how you can clarify your positive intentions for bringing up a problem and show respect for the other person while doing so.

Discuss: What factors are keeping our team from maintaining an environment of safety and support? How can creating a culture of safety and support help our team?



Read Chapter 1,
“Choose WHAT
and IF,” of *Crucial
Confrontations:*

*Tools for Resolving Broken
Promises, Violated Expectations,
and Bad Behavior*

Crucial Conversation #3

Mistakes

Question: Some docs can make incorrect orders. To be honest, we sometimes let it slide—especially if he or she 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 patient any sicker. Are you saying that I am supposed to just challenge the doctor even if he's abusive?

Answer: When you have no formal authority to confront a problem, you're actually in the best position to do it right. Often when we're "the boss" we believe we can just bark an order or register a complaint and by the sheer force of our authority people will comply. While this may work occasionally, it usually is not as effective as we think. It turns out that the more position power you use, the less likely you are to succeed when confronting problems. That's why often those with less power and more skill do it best.

This case is a good example of two problems bundled together—a potentially incorrect medication and a behavioral concern that makes it tough to deal with the mistake. The challenge is to confront the mistake and take the heat in the short term, but find a time later when you can take a few minutes to get to the root cause of why bringing up mistakes is so hard with this doctor. If you don't have this second conversation, you are leaving a key contributor to medical errors unresolved.

How, then, can you help a doctor who is behaving disrespectfully to stop? Especially when it seems he or she enjoys being abusive? The most effective way to motivate people to behave differently is to respectfully describe the natural consequences of their behavior to them. Natural consequences are those negative outcomes that are either already happening or may happen as a natural result of the person's current behavior (e.g., giving regular rather than timed release medication may cause this patient to react negatively). These are in contrast to imposed consequences—or those consequences that we impose on someone because we have power to do so (e.g., I'll write you up if you do that).

The challenge is to not just describe consequences we care about, but to give thought to consequences they care about. This might seem like a subtle distinction, but it is literally the difference between success and failure in a crucial conversation. The reason this is important is that if our motive is to punish or threaten, the natural consequences we describe may come across as guilt-tripping or moralizing and will provoke defensiveness. If we are less self-centered when confronting problems, we will give thought to consequences the other person is likely concerned about and will invite a significantly different response from them.

With that said, what are the natural consequences of a physician's disrespectful behavior? Specifically, what are some consequences he or she may care about?

- People begin taking liberties to change the medication without the doctor's consent
- The doctor loses the benefit of extra eyes and brains in avoiding errors
- Pharmacists and nurses are less willing to return to the prescriber to clarify orders when needed
- Morale is lower

If you begin by creating safety, then in a respectful way describe the natural consequences of the doctor's behavior—emphasizing your belief that these are issues you believe he or she cares about—you have the potential of influencing his or her behavior.

Discuss: Why is it important to focus on natural consequences of the issue at hand? How can holding conversations about mistakes, focused on natural consequences, increase the quality of service we give to our patients?



To create respect for the other person, read Chapter 6, "Master My Stories," in *Crucial Conversations: Tools for Talking When Stakes are High*

Crucial Conversation #4

Incompetence

Question: 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 the specialists who have to work with him would never put someone under his care. Sometimes I wake up in cold sweats thinking about this guy! How can you challenge someone's competence without it backfiring on you?

Answer: When people don't speak up about incompetence, it's often because they think their message will devastate the other person. They think the person won't be able to handle the message, and will retaliate or be crushed. Remember to begin by making it safe. Make sure the other person knows:

1. You care about his or her best interests.
2. You care about and respect him or her.

Notice it's not in the cardiologist's best interests to continue incompetent practices, and anyone who truly cares about him will tell him so. Here is an example of a way to establish safety in the first thirty seconds of this conversation:

"I'd like to talk to you about an important concern. I'm sure you don't realize it, but I think the way you do certain procedures may be putting patients at increased risk. I really value my working relationship with you, and I want to explore the details of this issue. I could also be wrong here, but thought I would be less than a good friend if I said nothing. Can I explain what I'm seeing and get your point of view?"

The goal is to make your respect for this doctor and his interests clear, and to be direct and completely frank about your concern. Next, describe one or two concrete instances—but then explain that you are seeing them as a pattern. For example:

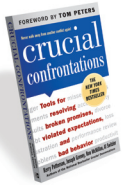
"The angiogram this morning showed 75 percent blockage, and you recommended an angioplasty. The most current data suggest we need other studies on heart function and total blood flow before making that recommendation. And while that's one example, I want to be clear that my concern goes beyond this morning's case. I'm concerned about how current you are on this kind of procedure. You often recommend angioplasties to patients who only show 75 percent blockage—and you rarely ask for additional studies. Is my data wrong here? Am I drawing an incorrect conclusion? I'd love to hear your perspective."

Now, what if the cardiologist responds, "I'll treat my patients however I think is best"? How do you handle this? The cardiologist isn't understanding the severity of the problem. Motivate him by explaining some of the natural consequences of his actions he might not be aware of. Your goal is to focus on consequences that are especially likely and that link to values he already cares about. For instance:

"A group of physicians and nurses is going to begin tracking risk factors related to patient safety. We hope to begin later this year. Right now the way you determine the need for angioplasties would be considered risky. You need to look into this or I worry you could be singled out as not up to date. I really want to help you avoid that."

If you begin with safety, focus on the right problem, and make it motivating, you'll find the person is more likely to be grateful than angry.

Discuss: When facing a crucial conversation, why is it important to make it safe? How can our team strive to create an environment of safety where we focus on the right problem and motivate others to uphold better standards of safety and quality?



Learn to better describe natural consequences in Chapter 4,

"Make It Motivating," of *Crucial Confrontations: Tools for Resolving Broken Promises, Violated Expectations, and Bad Behavior*

Crucial Conversation #5**Poor Teamwork**

Question: One of the docs in our practice is a real pain. He never answers his beeper when he's on call so the rest of us have to pick up the slack. Then when he does answer he's so surly that people don't want to go to him, so they dump on us instead. It's not fair. How should we approach him?

Answer: The problems that bother us most often contain a bundle of issues. This one includes at least two: First, you have a physician who is poor at answering his beeper when he's on call. Second, when people bring up problems, he becomes defensive, so the extra work gets dumped on you.

Both problems are important, but you'll want to address the issue with defensiveness first, because it affects the way you discuss any problem. Resolving it will make it easier to solve the pager issue as well as every other issue in the future.

Pick a place where the discussion will be private, and a time when the physician is likely to be at his best. Begin by making your respect for him and his interests clear, then be candid about your concern. For example:

“I have a concern about how we work together. Can we spend a few minutes discussing it? (Let him respond.) I respect our friendship, and I want us to be able to say anything to each other. I think that's important for the health of our team. Do you agree? (Let him respond.) Often, when I bring up a concern, I see you tense up. Sometimes you cut me off or jump in with a disagreement. I think you stop listening and begin defending. You may not realize how you're coming across—but that's how it appears to me and others. Do you realize you're doing that?”

Beginning the discussion this way will reduce the likelihood of the physician getting defensive. But what if he does get defensive—then what can you do?

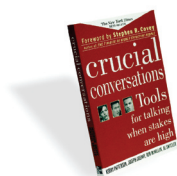
When people get defensive it's because they feel unsafe. Perhaps this physician has very thin skin and sees every criticism as an attack. To handle his defensiveness, step out of the content and restore safety. Once safety is restored, you can step back into the content without watering down your message.

Once safety is restored, the physician will calm down. Once he has, move back to the topic: his defensive reactions. Explain a natural consequence you've seen but he's probably missed. Remember, the key to motivating people to behave differently is to help them see more clearly natural consequences of their behavior they haven't considered.

“When you respond in a defensive way, people are nervous about giving you honest information. A nurse might be reluctant to call you in because of the reaction she expects from you. And that could get you and all of us in trouble. You wouldn't really know how sick your patient was. To be honest—people already think hard before bringing things to you. I don't think that's what you want.”

Once you've resolved the issue with defensiveness, don't wait to raise the issue of his reluctance to answer his beeper. Since you've already established safety and he's agreed to monitor his defensiveness, he's likely to be on his best behavior.

Discuss: How can approaching doctors or colleagues with my concerns about their poor teamwork improve our team? Will it increase productivity and efficiency? Will it elevate our standards of safety and quality?



Get better at sharing tough messages with Chapter 7,

“STATE My Path,” in *Crucial Conversations: Tools for Talking When Stakes are High*

Crucial Conversation #6**Disrespect**

Question: A group of physicians went right into a 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. I think I’ve tried to have the “crucial conversation”—what am I missing here?

Answer: This is a situation where the health of the patient needs to come first. You need to ask the physicians to follow the unit’s infection-control procedures.

Say something like,

“Excuse me. That patient is in isolation. You’ll need to suit up before going in.”

Let’s suppose this cardio surgeon’s reputation is accurate, and he responds by saying,

“You don’t know diddly about this patient. Go back to your crossword puzzle or whatever it is you’re doing! If I want your advice, I’ll ask for it.”

We’re not going to suggest you physically restrain the physician or put out a contract with the mob. But you do need to call for backup. You’ll want the support of your manager, other administrators, and other physicians. Document the exchange, and get help immediately.

Healthcare is changing, and this kind of disrespectful behavior has to go away. Most hospitals have standards that cover this kind of conduct, but some don’t apply them in a consistent fashion. If disrespect is an issue within your hospital, then it’s important to revisit your standards.

It’s hard to hold people accountable for standards they can’t remember or have been exempt from in the past. A key manager or physician needs to meet with this cardio surgeon, explain the standard and get his commitment to it.

One other note: Martin Luther King once said, “In the end, we will remember not the words of our enemies, but the silence of our friends.” If you observe one person being disrespectful to another, it’s your duty to speak up. If the cardio surgeon is disrespectful to the nurse, then one of the other physicians in the room should stop him. Silence is acquiescence, and makes you a partner in the offence.

Discuss: What risks are associated with rampant disrespect in our team? How can crucial conversations with physicians or colleagues who show disrespect affect our culture and patient safety?



Learn to restore safety with Chapter 5, “Make It Safe,” in *Crucial Conversations: Tools for Talking When Stakes are High*

Crucial Conversations: Tools for Talking When Stakes are High

Crucial Conversation #7

Micromanagement

Question: Nurses here exceed their authority. They'll change medications or treatment protocols without consulting the responsible doc. Every once in a while we have to rein them in or things will get really bad. What's wrong with putting people back in their places when needed?

Question: It frustrates me when a physician comes in, establishes the treatment plan for the day, then leaves without talking to me. I've spent the last twelve hours with the patient. I've tracked his or her vital signs, I've monitored what he or she's eaten, and I've talked with the patient about his or her concerns. I would think the physician would want my input, but instead I get a bunch of orders and a warning not to deviate from anything.

Answer: Micromanagement is always about crucial conversations that haven't been held. For example, a physician assumes a nurse is incompetent and so begins to micromanage. A better approach would be to talk with the nurse about your concerns with his or her competence. This actually requires less time overall because the nurse can then operate at a higher level of initiative on an ongoing basis.

If the nurse turns out to know more than the physician thought, the physician can feel comfortable backing off of the micromanagement. If the nurse turns out not to "get it," then he or she at least sees why the micromanagement is appropriate. In either case, the crucial conversation removes the concern about micromanagement. The nurse will be less resentful and more supportive of his or her decreased degrees of freedom.

Suppose you're the nurse who feels micromanaged. Your concern is that your expertise isn't being recognized. Let the physician know. For example,

"Some physicians ask me about my observations before setting up their treatment plan. You haven't been doing that, and I'm concerned you must not think I could add value. Is that right?"

Imagine the physician says, "No, you add lots of value. I'm just too busy to track you down." Make it more motivating to involve you by sharing some natural consequences the physician is likely to care about.

"I pick up a lot of information over the twelve hours I spend with the patient. I track her vital signs, know what she's eaten, and what her concerns are. Is there a way we could touch base quickly so I could make sure you've got all the info you need?"

At this point the physician may invite your participation. But then again, maybe you'll discover there are deeper concerns. Suppose the physician says,

"I've watched you at work. I think you're adequate at giving medications and starting IVs, but I have some real concerns about your assessment skills and your clinical judgment. I think you jump to some pretty crazy conclusions based on misreading very basic symptoms."

While this reaction could be disappointing, it represents real progress. The physician is being up front and honest with you. Ask for more details, and avoid being defensive. You can build a positive relationship by learning how the physician would like you to improve and what evidence he or she would need to see before feeling comfortable with your expertise.

Discuss: How does micromanagement hinder the productivity of our team? How can crucial conversations about micromanagement lead to a better working relationship with our physicians?



Learn to discuss a potentially unsafe topic with Chapter 5, "Make It Safe,"

in *Crucial Conversations: Tools for Talking When Stakes are High*

Dialogue Heals

The Seven Crucial Conversations® for the Healthcare Professional



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