What’s the best way to approach a surgeon who is repeatedly rude to a nurse who raises a concern about a patient’s informed consent?

What do you say to a nurse whose peers have been working around her poor assessment skills for years?

These conversations are about patient-safety issues, but they’re difficult because they involve confronting people, says David Maxfield, director of research at VitalSmarts, a company that studies and in-corporates best practices into management.

“Confronting people is hard,” Maxfield says. “If it were easy, we’d all do it. My father says it’s one of those skills you need to learn at your mother’s knee or some other low joint.”

Working with the American Associa-tion of Critical-Care Nurses in 2004, Maxfield studied 1,700 nurses, physicians, clinical staff, and administrators in 13 hospitals across the US.

The study identified conversations that are difficult but essential for health care professionals to master, resulting in the reports Silence Kills: The Seven Crucial Conversations for Healthcare and Dialogue Heals (www.silencekills.com)(sidebar).

His research also led to 2 management bestsellers: Crucial Conversations and Crucial Confrontations, published by McGraw-Hill.

Maxfield spoke with OR Manager about the findings and how to conduct crucial conversations.

What happens when we don’t have these crucial conversations?

Maxfield: We found failure to speak up is highly related to lower quality, lower morale, higher intention to quit, and lower productivity. The findings suggest that improving the ability to discuss these concerns could be a key variable in improving results and saving lives.

What are the most crucial concerns health care professionals need to talk about?

Maxfield: In our study, 1,700 health care professionals reported that an average of 10% of their co-workers engaged in the following behaviors and did so for long periods of time without being held accountable:

- broke rules
- made mistakes
- did not provide support
- were incompetent
- were poor team workers
- acted disrespectfully
- micromanaged or bullied.

Is the health care environment more open to these conversations now?

Maxfield: Yes, definitely. With the emphasis on patient safety, human errors can no longer be swept under the rug.
How do we have these crucial conversations?

Maxfield: For more detailed guidance, I recommend reading Crucial Conversations and/or Crucial Confrontations or viewing actual conversations on the website (www.crucialconfrontations.com).

Here are the basics:

Work on yourself first

You need to prepare yourself before you speak. First decide what the right problem is to discuss. Problems don’t usually come in tiny boxes; they come in giant bundles. Take the time to unbundle the problem and sift out the real or most presenting issue.

We use a skill we call CPR—Content, Pattern, Relationship. If your concern is with a single incident, “You arrived late for the briefing before this morning’s first case,” then you’re dealing with Content. If the problem repeats over time, “You often skip our briefings. You missed three today,” then you need to talk about that Pattern. If your real concern is about your working relationship, talk about that: “It’s common for you to skip briefings and leave before the case is over. I’m concerned about what you see your role to be here.” The mistake people make is to talk about a single incident when their real concern is far larger—involving a Pattern or Relationship.

Another task is to tell yourself the whole story—not just the one you first see or react to. Ask yourself a humanizing question, “Why would a reasonable, rational, and decent person do that?” rather than, “What’s the matter with that person?” This will help you understand what will motivate the other person to change behavior.

Confront with safety

The first 30 seconds set the tone for your entire conversation. Your overall goal is to confront with safety to avoid defensiveness. You must help the other person know you care about his or her best interests. To do that, we simply describe the gap—the difference between what you expected and what actually happened—rather than lead with unhealthy conclusions or accusations. Let the other person know your goal is to solve problems and make things better for both of you. Whenever the other person gets defensive, back up and recreate safety.

The second step in the confrontation is to motivate with consequences that matter to the other person, such as, “When you arrive late for the briefing, we often end up a bit confused. We don’t know how to help you the most. That can cause unnecessary delays.”

If the issue is about a person’s ability, explore root causes and workable solutions together. For example, “Some ORs use checklists to make briefings more complete and go faster. What could we do to make the briefings work for you?”

Move to action

Agree to a plan and followup method. Make a plan complete with the acronym WWWF: Who, does What, by When, and Follow up. Stay focused and flexible. As other issues come up, don’t meander. Consciously choose whether to change the discussion to the new issue.

What would an effective crucial conversation look like to address this scenario: A surgeon who is clinically respected and brings a lot of business to the hospital is verbally abusive to the nursing staff.

Maxfield: Disrespect and abuse require 2 kinds of solutions. First, there needs to be a clear prevention policy that is endorsed by the hospital. I work with a hospital that is implementing what they call their “Principles of Mutual Respect.” They’ve collected examples of sarcasm, insulting language, emotional blowups, and physical intimidation or attacks that must stop.

But they haven’t stopped there. They didn’t want to create one more line in the sand that physicians couldn’t cross. Instead, they’re making sure they solve problems for the physicians who are getting angry.
They found the most common reasons for blowups are that the patient arrived late or improperly prepped, a surgical technologist or nurse made a mistake that created a dangerous situation or a delay, or one of the staff was below par in a skill set. Adding the commitment to solve problems that led to the abusive responses makes it clear the hospital isn’t villainizing physicians. They are making the OR a more effective, efficient, and safe place to work.

For the actual conversation:

1. **Work on yourself.** Before holding the conversation with the surgeon, decide what the problem is. The problem isn’t the incident; it’s the pattern of abuse. Second, determine the mutual purpose—what is this surgeon trying to achieve, and why is the surgeon so frustrated? Third, ask yourself, what is it I really want long-term out of this conversation—for me, the surgeon, and for the OR? Finally, remind yourself why you respect this surgeon.

2. **Create safety.** Find a private place and ask the surgeon’s permission to bring up a problem. Make it clear you want to help, not attack, the surgeon. You say: “I’d like to talk about what happened this morning when the surgical tech wasn’t prepared. It was clearly a frustrating situation for you and for me, too. My goal is to make this place less frustrating—to make it more efficient, effective, and safe. Can we talk?”

Next, explain the gap and provide motivation: “You have very high standards, and I want to make sure all of my people meet them. I don’t want you to think I disagree with your standards. (A contrasting technique.) I want to talk about how you react when someone doesn’t meet your standards. You often say things like, ‘Are you trying to kill my patient?’ or ‘How did they let you graduate nursing school?’ Other times, you raise your voice and lash out at them or call them idiots. When you do that, the spotlight turns to you. I end up having to protect them when I’d rather be coaching them to fix the problem that has us all frustrated.”

3. **Move to action.** “I know nobody can change this sort of thing overnight. I’d like permission to give you some kind of signal when I see you starting to get upset. If I could give you a subtle reminder, you could catch yourself. Would that be okay?”

**Q What are the qualities of the 10% of health care workers who are already effective at conducting crucial conversations?**

**Maxfield:** They are able to speak up about difficult, touchy topics without attacking the person or watering down their message. They find a way to be completely frank and at the same time completely respectful. What we’ve learned from studying these people over the past 25 years is that their “gift” is actually a comprehensive set of skills that anyone can learn.

—Leslie Flowers

**Leslie Flowers is a freelance writer in Indianapolis.**

**References**


**Silence Kills: Major findings**

The study found a direct link between peoples’ ability to discuss emotionally and politically risky topics and key performance indicators, such as patient safety, quality of care, and nursing turnover. Highlights:

- Only 1 in 10 health care professionals speaks up when faced with safety concerns. Far fewer speak up if the concern is with a physician.
- 62% of nurses and 84% of physicians and other providers saw co-workers take shortcuts that could be dangerous to patients.
- 48% of nurses and 88% of physicians and other providers said they work with people who show poor clinical judgment.
- Fewer than 10% of nurses, physicians, and other clinical staff directly confronted colleagues about their concerns, and 1 in 5 physicians said they saw harm come to patients as a result.
- The 10% of health care workers who raised these crucial concerns observed better patient outcomes, worked harder, and were more satisfied and committed to staying in their jobs.

*Source: www.silencekills.com*