Clearly the nurse could have communicated more completely so the doctor could have made a better decision. Defined protocols for communication can help in this regard as well.

The doctor could have been more solicitous and probing to ensure complete understanding. But there was a deeper issue at play. One that is all too common in hospitals. And one that causes mistakes, undermines doctors’ effectiveness, burns out staff and raises costs.

The deeper issue was the doctor’s failure to address his long-standing concern with the nurse’s competence. He had long believed she showed poor judgment and had little trust in her assessments and recommendations. Furthermore, he felt he was the victim of her incompetence, as she would frequently awaken him in the middle of the night for trivial questions that a well-trained nurse should be able to handle.

How did this play into the nighttime disaster? In subtle, but very direct ways. The doctor’s failure to hold a crucial conversation with the nurse (or the nurse’s manager) about his competence concerns with her allowed the problems to persist. And the persistence of these problems irritated the doctor.

In a sense, since he failed to talk out the problem, he instead acted out the problem, through brusque comments, officious treatment towards her, and a tendency to minimize her concerns. This behavior caused her to operate less effectively than before. She procrastinated communicating with the doctor, and when she finally did step up to a conversation with him, she made it as brief as possible. And on that summer night, her brevity may have contributed to an unnecessary death.

Wouldn’t it be nice if 100 percent of a doctor’s time was spent on patient care?

No.

In fact, it’s that very fantasy that undermines the effectiveness of many doctors. The belief that anything that distracts from spending time on and with patients is non-value-added is one of the most damaging delusions in health care today.

Why? Because this belief motivates doctors to minimize the time and effort they spend influencing the systems they depend on to deliver the highest quality of care—systems that will never live up to their potential without the regular influence of the doctors who use them.

The increasing complexity and interdependence of our hospital systems demand that doctors regularly engage in some very crucial conversations. It is through these conversations that staff, policy, protocols and processes are developed. And when doctors minimize their involvement in these crucial conversations, the consequences to patients, hospitals and doctors are profoundly negative.

For example, on a summer night in 1994, a nurse was attending to a patient recovering from a colon resection. The incision was large, and the nurse was concerned because the wound was opening up. To make matters worse, the patient was nauseous, putting additional stress on the incision.

The nurse called the surgeon who immediately expressed irritation at the interruption of his well-earned sleep. In her confusion, she hastily and minimally described the situation and left out important information, leaving the doctor to conclude that the situation was manageable if the nurse would simply redress the wound. She did.

The patient later threw up and popped the stitches. His organs spilled onto the bed. And shortly thereafter he died.

So what went wrong here?

Knowing No Boundaries: Five Crucial Conversations for Influencing Administration

By Joseph Grenny
In a recent study of 1,700 doctors, nurses, administrators and other clinicians, we found that this kind of pattern is unfortunately common (see www.silencekills.com). We found there are five crucial conversations that physicians tend not to hold that undermine their influence, diminish the quality of care their patients receive and damage physician morale.

Furthermore, we found that doctors who consistently and effectively held these five crucial conversations reported higher satisfaction in their relationships with hospital staff, better quality of care and higher productivity.

**Five crucial conversations**

The five conversations doctors tend not to hold, that are profoundly related to better results include:

1. **Concerns with competence**—81 percent of doctors report having concerns with the competence of at least 10 percent of the nurses with whom they regularly work. Two out of three doctors have similar concerns with at least one other doctor. And a significant number have seen harm result from these people’s perceived inabilities. And yet fewer than 1 in 12 doctors have raised concerns with nursing staff in an effective way despite reporting that the problems have persisted for 1 to 5 years or more. If the concerns are with another doctor, less than 1 percent has effectively brought up their concerns. The cost of this failure is that problems persist, the doctor with the concerns acts out his or her concerns by attempting to work around the problem, and all too often quality of care suffers.

2. **Administrative decisions**—93 percent of physicians express frustration about decisions administrators make that affect them. For example, in one hospital orthopods were greatly affected by a decision to give them two rooms instead of three. And yet less than one in five took the time to speak to the right people in the right way to try to exert influence over these decisions.

3. **Mistrust of administration**—In the high stress world of health care—particularly with values like cost, quality and access in constant tension—it’s no wonder that trust issues abound between doctors and administrators. What contributes to the intensity of this problem, however, is the parties’ failure to directly, candidly and effectively express concerns about mistrust in a way that leads to productive solutions. In the survey, 97 percent of doctors reported concerns that administrators fail to consider their interests. And yet most doctors have only expressed these concerns to their colleagues or others who have little influence to make things better.

4. **Staffing problems**—More than 80 percent of doctors have concerns about staffing and other obstacles that make it hard for them to deliver high-quality care. For example, a hospital may be trying to use more nurse practitioners, nurse anesthetists, midwives or other non-physician care providers. But once again, very few productively and effectively influence these issues. Some will send an angry e-mail or complain to a medical director. But few truly step up to the crucial conversation in a way that yields influence. The result is that doctor influence is minimized and problems persist. The doctors get more frustrated. And administrators develop a bias for excluding doctors in future decisions.

Most people labor under the misconception that when others get defensive it’s because the message was just too tough for them to take. This is largely untrue.
The goal of a crucial conversation is dialogue not monologue.

5. **Protocol and process problems**—
   Over two-thirds of doctors report being left out of even clinical decisions that directly affect them. At the same time, the vast majority of administrators complain that their attempts to involve doctors are met with resistance, apathy or obstinacy. Who’s right here? In our experience, they’re both right.

   The important message here is that doctors tend not to engage in these crucial conversations because they frequently underestimate the consequences of not engaging. Our research suggests that they do so at their peril.

   When they minimize involvement in improving staff, policies, protocols and processes, they remove one of the most potent and intelligent sources of influence from the systems they depend upon—their own influence. The result is that they contribute subtly—but directly—to the very problems that hurt them and their patients.

**Crucial conversations best practices**

And yet, the research also shows that some doctors do take the time to step up to these conversations. And those who do so skillfully report better outcomes for themselves and their patients.

We’ve spent thousands of hours observing physicians and others who successfully step up to crucial conversations and offer some advice gleaned from those who do it well.

Some of the advice illustrates how these skillful doctors think differently about the conversations. Other elements describe how they act. Taken together, these best practices increase physician influence in a profoundly positive way.

**Consider the risks of not speaking up.**

Interestingly, the first difference between those who are consistently effective at crucial conversations and the rest of us is how they think about the conversation itself. When deciding whether or not to give feedback to a less-than-competent peer, most of us are paralyzed with fear because we immediately think of all the bad things that might happen if we speak up.

For example, “They will be offended. They will begin to bad-mouth us. They certainly won’t agree with the feedback. So why bother?”

A crucial difference of skilled communicators is that they assess risk completely differently from others. They don’t think first of the risks of speaking up. They think first of the risks of not speaking up.

Now, they are not foolhardy. They are aware of political sensitivities. But they refuse to make these sensitivities the sole consideration. It turns out, if you first consider the risks of speaking up, you tend to almost never speak up. If you think first of the risks of not speaking up, you will venture forward far more often.

**Control your emotions by controlling your story.**

When we want very badly to speak up, that’s how we typically do it—badly. You can’t produce good outcomes from a crucial conversation if you can’t get your emotions in check first. Never speak up out of anger—the consequence of doing so is less, not more, influence in the long run.

The good news is this skill is an exercise of the brain not the mouth. Our emotions are not a function of what is happening outside us. They are a function of what happens inside—the stories we tell in our heads about why people are doing what they’re doing.

The best communicators are conscious of the exaggerated judgments and over reactive conclusions they tend to draw when someone causes them pain and inconvenience. They then challenge these judgments by asking, “Why would a reasonable, rational and decent person do this?” Questions like this provoke you to rethink your assumptions and attributions in a way that softens emotions.

**Start with safety.**

Most people labor under the misconception that when others get defensive it’s because the message was just too tough for them to take. This is largely untrue.

We’ve observed literally thousands of crucial conversations and see almost no correlation between the risk of the message and the ultimate success or failure of the conversation. What does predict success or failure is how safe you can make the other person feel while hearing your message.

Your task in the first 30 seconds of a crucial conversation is to
ensure the other person knows two things:

1. That you care about their interests and concerns
2. That you respect them

If you succeed in communicating these two points, they will be able to consider and absorb your message—even if they don’t like it. If you fail to communicate these two things, over 90 percent of the time they will resist you.

**Stick to the facts.**

Your next task is to lay out the factual basis for your concerns. For example, if you believe administration is inappropriately leaving you out of decisions, you are obligated to share concrete examples of your concerns. The mistake most people make in this step is that they mix “hot words” in with their facts. Hot words express your negative judgments about the facts.

For example, you might say, “You intentionally scheduled three meetings on changing feeding protocols in the neonatal unit at times you knew I couldn’t attend.” The hot words here are the accusations about administration’s intent behind their scheduling activities. Your judgments about their intentions are not facts—they are your opinions. They may or may not be true. What is true is that they scheduled the meetings at times with which you had conflicts. This is what should be shared first.

As you lay out the facts you can eventually share why these facts concern you, but you’ll do so in a way that allows you to check your judgments out with the other parties rather than communicate them as accusations.

**End with a question.**

The goal of a crucial conversation is dialogue not monologue. Once you’ve described your concerns, you must demonstrate your willingness to engage in dialogue by encouraging the other person to share even opposing views with you.

We’ve learned through extensive observation that people are perfectly willing to let you express a strong opinion so long as they are convinced you are equally willing to listen to their opposing one. You can demonstrate this sincere interest with a statement like, “Do you see this differently? I’d very much like to hear your views.”

Our research suggests that the doctors who provide the best care are not the ones who spend 100 percent of their time on patient care. It is the ones who willingly spend some portion of their time holding conversations that are crucial to continuous improvement in the systems that enable high-quality care.

Joseph Grenny is co-author of the New York Times bestsellers Crucial Conversations and Crucial Confrontations. He has consulted with more than 300 of the Fortune 500 on corporate change initiatives over the past 30 years. Grenny can be reached through his company’s website at www.vitalsmarts.com.