

Avoiding Difficult Conversations in the Australian Health Sector

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Abstract

Background: Health professionals avoiding difficult conversations with each other can lead to serious negative consequences for patients. Clinical supervisors are in the unique position of interacting both with students as well as colleagues and peers. This study explores the avoidance of difficult conversations from the perspective of clinical supervisors in order to better understand why health professionals avoid difficult conversations.

Objective: This study aimed to identify the reasons why difficult conversations are avoided between health-care professionals and to gain deeper insight into the phenomenon of avoiding difficult conversations in general.

Methods: Convergent interviewing was used with 20 clinical supervisors to explore the following question: *Why do you think that people in your workplace avoid difficult conversations?*

Results: Major reasons for avoiding difficult conversations included the fear of negative consequences, a general distaste for confrontation, and a lack of confidence in their skills to have such conversations. Additional factors included individual qualities such as personality type and communication style, available time, size of the workplace, and a range of perceived cultural barriers standing in the way of having difficult conversations.

Conclusion: There is a need to encourage clinical supervisors and other health professionals to embrace difficult conversations to reduce adverse events and enhance patient outcomes. This requires additional training and educational opportunities to enhance knowledge, skills, and confidence to plan and engage in difficult conversations. Some types of difficult conversations require more skills than others.

Keywords

medical errors, avoiding difficult conversations, crucial conversations, clinical supervision, clinical placement, health education, nursing, allied health personnel

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Most of the literature about difficult conversations in the health sector are related to those between medical professionals and their patients and/or patients' families (Corless et al., 2009; Davenport & Schopp, 2011; Kalra et al., 2013; Lamiani et al., 2012; Meyer, 2014; Stott, 2007). There is however, a gap in the literature about difficult conversations that take place between health-care professionals including students. Avoiding these conversations is associated with higher rates of medical errors and poorer patient outcomes (Williams et al., 2017). For example, the "Silence Kills" study that used focus groups, interviews, workplace observations, and survey data from more than 1,700 nurses, physicians, clinical staff, and administrators identified

seven different crucial conversations that are often avoided and correlate strongly with medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover (Maxfield et al., 2005). These conversations should be taking place on a regular basis and include discussion about broken rules, mistakes, lack of support,

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incompetence, poor teamwork, disrespect, and micromanagement.

Another study, "The Silent Treatment," found that more than 80% of nurses had concerns about dangerous shortcuts, incompetence, or disrespect; more than 50% say shortcuts have led to near misses or harm; more than 33% say incompetence has led to near misses or harm; and more than 50% say disrespect has prevented them from getting others to listen to or respect their professional opinion (Maxfield et al., 2011). In addition, fewer than 50% of these nurses have spoken to their managers about the person who concerns them the most; and fewer than 33% of these nurses have spoken up and shared their full concerns with the person who concerns them the most. To explore these same issues in Australia, Williams et al. (2017) carried out a small pilot study informed by the Silence Kills and The Silent Treatment studies. In this study, 65% of participants believed that some colleagues demonstrate behaviors which could be dangerous for clients. Participants also reported that a client had been affected due to the poor performance of someone in their health-care team and 35% said that they would feel uncomfortable to have that person look after a family member. Participants were then asked to reflect on the person whose underperformance created the most danger for clients, and only 23% had spoken to the person and expressed their concerns. Also concerning was that 45% of participants reported avoiding at least one difficult conversation within the last month. The reality is that it is all too common for difficult conversations to be avoided in the health-care workplace.

Some studies have estimated the human and financial cost of avoiding conversations by linking these conversations to adverse events (AEs; Williams et al., 2017). An AE is an "unintended injury or complication resulting in prolonged hospital stay, disability at the time of discharge, or death, and caused by healthcare management rather than the patient's underlying disease process" and it is estimated that approximately half of these events are preventable (de Vries et al., 2008). A study by Waring (2005) showed that in the national health service of England and Wales, mistakes or "adverse events" occur in 10% of inpatient admissions and the human cost of these mistakes has been the loss of 40,000 lives and a financial cost of over 2 billion pounds in additional care. A study by Kalra et al. (2013) showed that 1.5 million preventable AEs occur each year in American hospitals. A total of 44,000 to 98,000 deaths occur each year due to medical errors; 45 cents of every dollar spent in the United States is related to medical mistakes; and 3.5 billion dollars per year are spent due to in hospital adverse drug events (26% of all preventable AEs). To put this in perspective, Kalra et al. highlight that more Americans die each year from medical errors

than from motor vehicle accidents, breast cancer, or HIV/AIDS.

The impact of medical errors in Australia is also a concern. In one study examining the impact of medical errors in Victoria, it was found that 7% of routine admissions were associated with an AE (Richardson & McKie, 2007). The Quality in Australian Health Care Study in 2005 (QAHCS; Wilson et al., 1995) examined medical records for 14,000 admissions to 28 hospitals in NSW and SA and found that there were 470,000 admissions/year (10–15% of hospital admissions) associated with an AE leading to approximately 18,000 deaths and 50,000 cases of permanent disability. In the QAHCS, it was shown that 50% of the AEs had a high preventability score and 60% of deaths could have been avoided. The direct hospital costs of AEs, both fatal and nonfatal, was estimated in the QAHCS at \$900 million per/year. As a result, a number of strategies were implemented by the Australian Council for Safety and Quality in Health Care, but 10 years later in 2005, it was concluded that there was insufficient evidence to determine whether any of the effort has increased safety in Australian hospitals (Wilson & Van Der Weyden, 2005).

Today, over 20 years after the QAHCS, the impact of medical errors and how avoiding difficult conversations contributes to these errors is still a major concern in Australia (Williams et al., 2017). The issues surrounding why people avoid difficult conversations are complex and varied, as are the potential impacts to patients when such conversations are avoided. For example, the Silence Kills study suggests a number of reasons why health-care professionals avoid difficult conversations including people's lack of ability to have a difficult conversation, low confidence that it will do any good to have the conversation, fear of retaliation, lack of time, and a belief that it is not part of their job (Maxfield et al., 2005). Our study explores the avoidance phenomenon from an Australian perspective, and also from the perspective of clinical supervisors who interact with a broad range of students as well as peers and colleagues in the health sector. It uses a convergent interviewing process that enables deeper level insights to be gained about complex phenomenon than traditional interview techniques, to explore the question "Why do health professionals avoid difficult conversations in the workplace?"

Methodology and Methods

Design

To explore why health professionals avoid difficult conversations, an inductive, action research-based interview method known as convergent interviewing was used. This method was created to explore issues in

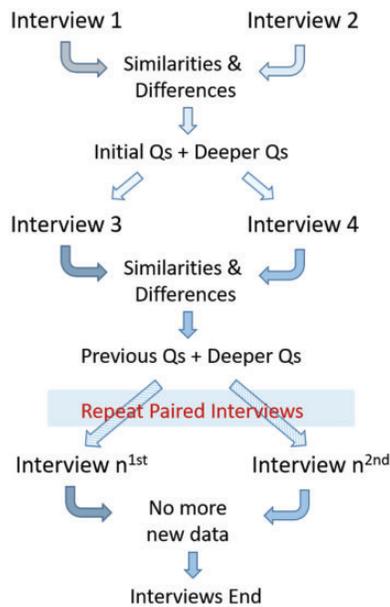


Figure 1. The Convergent Interviewing Process.

underresearched areas and aims to collect, analyze, and interpret people's knowledge, attitudes, beliefs, and experiences that converge around a set of interviews (Dick, 1990, 2007). This method has been used in a number of health contexts including paramedic medicine, obesity management, and people management issues in health care (Cochrane et al., 2017; Rodwell et al., 2010; Thynne & Rodwell, 2018). The interview process can be seen in Figure 1.

The process begins with developing an initial broad question and then asking this question to each of the first pair of interviewees, separately. The interviewer then analyzes the two data sets and looks for convergent or divergent information and constructs deeper level questions that tests for convergent and explores divergent information. These are then added to the initial broad question, and asked to the next pair of interviewees, separately; and so on. For example, if the first interviewee of the pair said that the sky was green and the second interviewee of the pair said it was blue (i.e., difference in data) then a deeper level question would be constructed to find out why: "In previous interviews, some people have said the sky was blue and some said it was green, why do you think there were these differences in perceptions?" However, if both interviewees said the sky was blue (i.e., similarity in data) then a confirming question would be asked: "So far, everyone we have interviewed has said the sky was blue, can you think of any situations where this was not the case?" The deeper level question would then be asked to the next pair of interviewees. Through this deeper level of questioning, themes emerge from the data, and these form the basis of

the results. This process is repeated until the saturation of ideas/knowledge is reached.

An assumption of this method is that the interviewer (an outsider) does not have as much knowledge as the interviewees (insiders) about the situation, so is not well equipped to design and develop a list of interview questions. That is, the participant data help to frame deeper level questions which are not possible with more traditional interview methods. King (2000) notes secondary benefits of convergent interviewing including shared learning in the way in which deeper level questions are asked, and ownership, where participants recognize that the questions being asked are reflective of participants' knowledge and that the interviewer is genuinely listening.

Participants

Invitations to participate in the study were sent out by email to 113 health professionals who also supervised students in their workplace. These clinical supervisors were also past participants of a 1-day "Difficult Conversations" skills-based workshop focused on overcoming difficult conversation that was run throughout Victoria in nine locations. A total of 40 clinical supervisors responded with suggested dates and times over a 2-week period. Of these 40, interviews were conducted until the saturation of ideas was reached at 20 interviews. Interviewees were selected based on their availability and where participants had coinciding times, the first to respond was given their preferred interview time. The interviewer also ensured a cross section of participants (e.g., age, gender, location, and clinical supervision experience). Further information about the Difficult Conversations workshop can be found in Williams et al. (2016).

Data Collection

Each interview took approximately 1 hour and consisted of two parts. Part A aimed to explore why difficult conversations are avoided in the workplace and Part B aimed to find out what workplace environment is needed to enable difficult conversations. This article reports on Part A and used the open-ended question: "Why do you think other people in your workplace avoid difficult conversations?" Interviews were carried out by phone and interview data were typed into a word document verbatim by the interviewer, as the interview took place. The interviewer (one of the authors) has over 20 years' experience in this type of method and asked questions and prompted and typed responses during the interview. Interviews were also recorded so that the interviewer could fill in any words that were missed immediately after the interview.

Data Analysis

The interviewer spent approximately 2 hours after each pair of interviews looking for similarities and differences in the data. These were then used to construct new additional questions to be asked to the next pair of interviewees, to confirm, disconfirm, and explore at a deeper level. The time to do this analysis throughout the process had to be factored into the interview schedule. The convergence of the data led to a number of themes being identified along the way. After the interviews were completed, the interviewer wrote up the emergent themes, referring back to the data to check assumptions, explore further depth for each of the themes, and select interviewee “quotes” that were representative of convergent views that could be used to highlight the main themes.

Ethics

Ethics approval was received from the relevant health service and university human research ethics committees.

Results

A total of 20 health professionals took part in the study. In addition, 10 were nurses, 8 were in allied health (5 speech pathologists, 2 physiotherapists, and 1 community support worker), and 2 were in medicine. Of these 20, 2 were from the private sector and the remaining 18 were in the public sector. With respect to practice location, there were two rural, eight regional, and eight metropolitan participants. No participants identified as being remotely located. Of the 20 participants, 18 indicated that they had some previous form of training in clinical supervision, with 8 indicating formal qualifications in clinical supervision. Table 1 shows the years of experience of participants in the health sector and as a clinical supervisor.

Nine themes emerged from the convergent interviewing process (Figure 2). Each of these are described later. Direct words or quotes of participants are presented in italics.

Theme 1: Negative Consequences of the Conversation

The consequences resulting from having a difficult conversation were the most commonly discussed issue across the participants. Consequences that

participants reported included not wanting “any backlash” (e.g., being talked about and being reported on to superiors), not wanting the person to feel hurt, feeling disliked, people seeing it as a personal attack rather than professional, relationships becoming more tense and awkward, and facing the person the next day or week.

Theme 2: Fear of Confrontation

Difficult conversations were also seen to potentially lead to confrontation and participants reported that people in their workplace are afraid or fear confrontation, want to avoid conflict, and “keep the peace.” That is, they were afraid of the confrontation itself, and not just the consequences of it. There was also a perception that with difficult conversations it was difficult to predict whether a conversation would become confrontational, and if it did, what the level of confrontation would be, leading to uncertainty. For example, one participant wished that all staff “...weren’t fearful of confrontation...confrontation is not always bad and its better than calling me up days later ... and by then it has escalated.”

Theme 3: Lack of Skill

Another main reason for avoiding conversations was a lack of confidence brought about by a lack of skill in not only having a difficult conversation but also in planning and reporting on this type of conversation. As one participant expressed “Having the skill is important. Some people have it innately and others don’t...but it is needed.” Lack of skill in addressing and managing conflict if a confrontation was to arise was also mentioned as a reason to avoid a difficult conversation. For example, “If you don’t have the skill you could make the situation worse by having the difficult conversation. If you have skill you can usually make it a positive outcome.” Participants also talked about the influence of staff perceptions about others’ experience and skill level in having difficult conversations. If a person in the workplace was seen as highly experienced in these types of conversations, then they were more likely to be engaged with in a difficult conversation, and this would also make the conversation itself less difficult.

Table 1. Length of Experience of Clinical Supervisors.

Year of experience	Nil	Less than 1 year	1–4 years	5–10 years	11–15 years	16–20 years	More than 20 years
Health sector	0	1	3	4	1	2	9
Clinical supervision	0	3	6	4	4	1	2

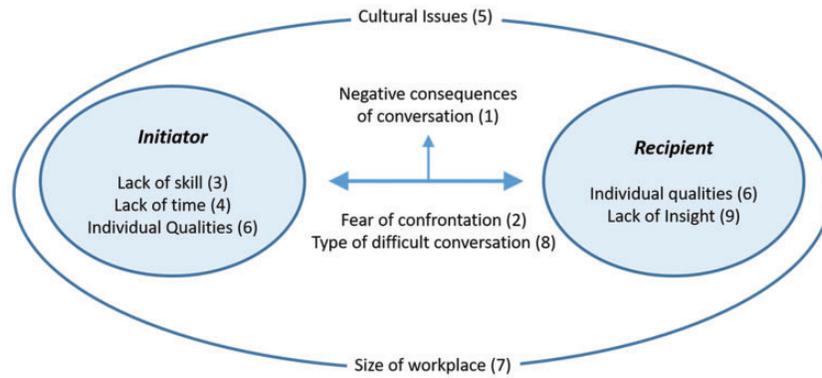


Figure 2. The Complexity of Avoiding Difficult Conversations.

Theme 4: Lack of Time

The time to plan and have a difficult conversation was another reason these conversations were avoided. As one participant stated “we are so busy often that we don’t really have time to critique performance and then spend time talking about it later [in a difficult conversation] if we need to.” However, when asked in more depth about the influence of time, many participants stated that if a conversation was very important than most people will make time. Having these conversations in terms of time was seen as an “extra burden on an already burdened workforce.” From the participants’ perspectives, whether or not a difficult conversation is important enough is dependent on the judgment of the person wanting or needing to have the conversation.

Theme 5: Cultural Issues

Participants also reported a range of cultural issues including a culture of not wanting to “dob” on others, a culture where people find it particularly hard to report unprofessional behavior, a culture of making up for someone else’s “slack,” and a culture of not wanting to take the lead and passing the responsibility of a difficult conversation onto someone else. Different types of cultures were identified by participants: An Australian culture where people often beat around the bush and do not get to the point, particularly when you have to tell someone they are not good at their job; a nursing culture where senior nurses were not trained to embrace professional supervision and conversations can be quite harsh; a culture of medicine where you do not question your seniors, nurses do not question doctors, and having these conversations is not really part of your job; a speech therapy culture where how you communicate is just as important as what you communicate; and an organizational culture where every organization has its own type of communication, structure of hierarchy, and own way of wielding and yielding power. Different ethnic cultures

were also mentioned as a reason to avoid difficult conversations where there was a higher risk of misunderstanding each other. Participants also reported differences between rural and urban cultures; however, there was little convergence or agreement about how these differences influence avoiding difficult conversations.

Theme 6: Individual Qualities

Almost all participants mentioned an individual’s personality type and communication style as influencing whether or not a person was more likely to avoid a difficult conversation. As one participant described:

Some staff can be as blunt as a sledge hammer... and because they are not gentle it comes down on a student like a ton of bricks. Personality could be described as abrasive of some clinicians but they are great clinicians... there’s a fine line between assertive and aggressive... and often students are passive... so they feed off each other

Almost all participants reported that it was more difficult to have a difficult conversation with a senior than a peer, and the least difficult to have a difficult conversation with a student or junior. Although it was acknowledged by some that it also depended on what the conversation was about and the personality of the people involved. Avoiding conversations was also seen as being influenced by what was modeled by seniors, and this was especially true for staff working in teams. That is, if a senior avoided difficult conversations, staff were likely to follow suit. Participants also perceived that the larger the age difference between two people, the more difficult the conversation is likely to be, resulting in the greater the likelihood of the conversation being avoided. Overall, in terms of individual qualities, participants perceived that being uncomfortable with a person was a very large factor in

avoiding a difficult conversation with them. Some participants commented that difficult conversations are often with difficult people and that feeling uncomfortable is often greater before a conversation compared with when a conversation is actually happening.

When asked whether the ability to have a difficult conversation in the workplace was influenced more by individual qualities or by cultural issues, some people believed it to be mainly individual, for example “It is the individual...you can have no problem with one person and ongoing problems with another person...based on personality not culture; and some people believed it to be cultural, for example “It’s definitely culture...a people culture...supervisors haven’t grown up with adequate supervision themselves...it’s not modelled and it wasn’t part of their profession...so it’s become an organisational culture.” However, the majority of participants perceived that avoiding difficult conversations was influenced by a mix of both personality and culture:

I think if you are an individual and you start in a ward where no one talks...you adapt to the culture in the area. It may be easier to change an individual than a culture. A strong personality could put someone off. In the medical profession...you don’t question your seniors. It is both – you can have a culture that encourages the conversation and you have an individual that won’t have the conversation.

Theme 7: Size of Workplace

Size of the workplace was mentioned by participants in all professions as influencing whether conversations were avoided; however, participants were divided about the potential effects of workplace size. Both settings present unique challenges. One participant said:

... if you have a larger organisation...you might be more inclined to not have that conversation as you might not see them as often. In a smaller one you might cross paths more...so you have to have the conversation.

As another participant noted, smaller organizations have their challenges as well: “In a smaller department everyone knows what is happening so it’s harder to have them. In a big department, there is a better hierarchy and not everyone knows everything.” That same participant also felt that the larger the organization, the more likely that there are rigid policies around feedback and supervision. Other participants echoed this sentiment by saying, “Large departments can be an asset...it forces people to put processes in place and makes sure things

are not swept under the carpet,” while another participant also noted that it is “... easier to have these conversations in a bigger organisation as you usually have a better framework set up.” Another benefit of a large organization was that “there is often someone else that can have the difficult conversation for you.” Interviewees also linked the size of an organization with the influence of either cultural or individual traits, for example

I think I see more difficult conversations taking place in small [organisations] because you see it more... in large organisations it is absorbed. In large organisations culture has a bigger impact than individual... and in small organisation, the individual is greater than culture.

Theme 8: Types of Difficult Conversations

Difficult conversations were generally placed into two categories, those relating to clinical skills and those related to attitudes and behavior. Participants believed that conversations about someone’s attitudes and behaviors were more difficult than those about their clinical skills and were therefore more likely to be avoided. In terms of attitudes and behavior, things such as commitment, professionalism, standard of care, and lacking insight were frequently mentioned. Although these were mentioned for both staff and students, many participants felt this was a greater issue for students. Students were described as having a “lack of respect,” “behavioral problems,” an expectation that “others need to fit in with them,” a lack of professionalism, and increasing mental health issues. As one participant explained:

Most of our difficult conversations are to do with students either not performing properly or they have done something wrong or a mistake... and it’s mainly something to do with their attitudes and behaviour

Participants also noted that it was harder to have a conversation with a student about “who they are” compared with “what they did.” That is, it is harder to have a conversation about attitudes than behavior, and about behavior than clinical skills. Clinical skills were also seen as easier to report on than behavioral issues and the most commonly used phrase to describe difficult students were students who “lacked insight.”

Theme 9: More Difficult Conversations About Attitudes and Behavior Are Heavily Influenced by “Lack of Insight”

Lack of insight was seen as the most difficult to address in conversation, particularly when this was about

making a change to behavior. Lack of insight was described by participants as the inability to self-reflect and take on feedback and was used to describe both staff and students. As one participant explained; “I have to say, the most difficult conversations are about the student or staff that lacks the insight about what is going on.” With respect to students, participants reported that giving feedback about clinical skills was often received positively and students would see it as an opportunity for improvement. Giving feedback about behavior however, was often received negatively, and students can see it as a direct attack on themselves, or do not see it at all (i.e., lack insight). When specifically asked to expand on lack of insight with regard to students, participants explained it to be when a student could not see that there was anything wrong with their behavior, even when it was brought to their attention. The importance of this was emphasized by participants who linked clearly the influence of attitudes and behavior on interactions with patients. Behavioral issues of a student lacking insight can be seen by those around them but not by the person themselves. Some participants suggested that any conversations related to “change” were difficult and not well received. As one participant described difficult conversations: “They’re about change, wanting to make change, or not happy about a change process, or asking for something to be changed . . . and not everyone receives that well.”

The nine themes show that the reasons difficult conversations are avoided are complex and as such it is useful to present them as a systems model. When a systems approach is taken, four system levels need to be considered: the components, the interaction between the components, the emergent properties of this interaction, and the wider system (i.e., context) that these are all embedded in. Figure 2 is a systems model of the themes that emerged in this study. The different levels in the model are useful in identifying where efforts are needed to help overcome difficult conversations and also highlight the systemic nature of the problem at hand.

Discussion

The study showed that the reasons why health professionals avoid difficult conversations are complex. The main reasons were related to the interaction between the initiator and recipient and what this would lead to, namely, anticipated negative consequences and a fear of the confrontation itself. Reasons also included those that directly relate to the initiator of the conversation including lack of skill in having difficult conversations including conflict management, lack of time (to prepare and have the conversation), and their individual qualities (e.g., personality type and communication style).

Whether the conversation was with a senior, peer, or junior was also important, the former feeling the most difficult and the later the least difficult. Other reasons included those that relate to the person the initiator is having the conversation with (the recipient). These include individual qualities such as personality type and communication style, but also whether or not the recipient “lacks insight” and finds it difficult to be self-reflective about their own attitudes and behaviors and how these affect others around them. If a person in the workplace lack insight, then others are more likely to avoid a conversation with them as they feel the conversation is not likely to resolve anything, is frustrating, and is a waste of their time. Other wider system issues also influence difficult conversations being avoided, particularly a range of cultural issues (e.g., national culture, nursing culture, and medical culture) as well as the size of a workplace.

The findings can be compared with other studies in the literature. To compare with a setting outside of health care, the classroom setting, Abrams (2006) notes that people avoid difficult conversations because of the desire to be pleasing to others including both the avoidance of appearing mean as well as wanting to be liked and respected by others; maintaining safety in terms of both emotional comfort (avoiding any potential emotional pain or discomfort) and job security (fearing the attempt could jeopardize one’s employment); an organizational culture where people do not face things head-on; power/control differentials where one person may not feel they have the authority or position to undertake the conversation, or feels the other person has power, which makes them hesitant; priorities, such as a lack of time due to other pressing concerns; or a personal identity based on one or more characteristics that leaves one feeling that they would not be taken seriously. These factors mirror many of those revealed by this research, indicating the similarity between a classroom setting and the health setting. From the management literature, Chism (2014) suggests that the two main barriers to having difficult conversations are the fear of the other person’s response and emotional discomfort. These were also two of the main reasons found in our study.

Comparing with research from the health sector, the “Silence Kills” study related to difficult conversations around workplace performance (Maxfield et al., 2005) cited the three major obstacles as “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 . . .” (p. 6). Two additional reasons frequently cited by participants in the study include lack of time and fear of retaliation. Perhaps more fundamentally, the choice of whether to avoid or confront in the health sector setting is what could be called a “false choice.” Communication has been found to be the root cause of over 60% of the

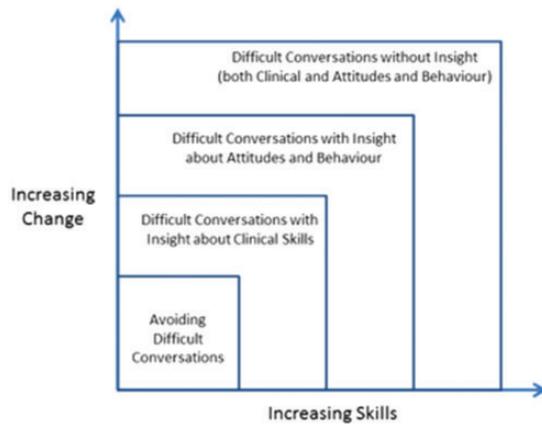


Figure 3. The Extent of Change and Skills Required Depending on the Type of Difficult Conversation.

sentinel events reported by the Joint Commission year after year (Ulrich, 2007). For example, in 2018, falls were the second highest cause of sentinel events (after unintended retention of a foreign object) and the second highest contributing factor was identified as communication failures (after inadequate assessment). Communication failures was higher than lack of adherence to protocols and safety practices, inadequate staff orientation, supervision staffing levels or skill mix, deficiencies in the physical environment, or lack of leadership (The Joint Commission, 2019). As Polito (2013) notes, an avoided difficult conversation does not make the underlying issue(s) go away, which is why "... best practices and evidence-based management guide us to the decision that quality improvement dictates effective communication, even when difficult" (p. 143). The focus can then shift to what makes for more effective communication in difficult conversations.

The study also showed that the more difficult a conversation was, the more likely it was to be avoided. Conversations were seen as difficult when they are about a person having to make a change. The degree of difficulty depended on what the conversation was about, the least difficult being about clinical skills and the most difficult about needing a change in behavior and/or attitude with a student or staff member who "lacks insight." Deeper learning and more skills are required in conducting difficult conversations in the later situation than in the former, in accordance with a range of different theories addressing different levels of learning (Argyris & Schon, 1996; King & Cruickshank, 2012; Valice et al., 2014). Figure 3 illustrates one of the main insights and conclusions of this study in relation to what most difficult conversations are about and the skills required by staff to have difficult conversations. Comparing our findings to that of the Vital Smarts Silence Kills study of Maxfield et al. (2005) to the results

of this research, the broken rules, mistakes, and incompetence fall under issues with clinical skills, while lack of support, poor teamwork, disrespect, and micromanagement fall under issues with attitudes and behaviors. There are also differences in the skills and culture change required to enable difficult conversations between health professionals themselves compared with those needed between health professionals and patients (Cheng et al., 2017, Kim et al., 2019, Makary & Daniel, 2016, Williams et al., 2016). This diagram can be used when designing training in terms of both process (e.g., introducing deeper level learning over time) and content (e.g., ensuing skills cover the entire spectrum), as part of training for reflective practice, and as a management or education tool (e.g., appraisals and skills audits).

The findings of this study reveal a need to provide clinical supervisors and other health professionals more training and other educational opportunities to enhance their knowledge, skills, and confidence to plan and engage in difficult conversations. As training is scaled across and up, wider system issues will also be addressed, and by doing so the culture of silence around difficult topics can begin to be replaced with an enabling culture that better serves patients and health professional including clinicians and students.

Recommendations

The findings of this study, represented as themes, help to provide a basis for the following recommendations:

1. Training is needed to assist in a deeper understanding of, and more confidence in having, difficult conversations, including an understanding about why some conversations are more difficult than others.
2. A more systemic approach is needed in the implementation of current and new strategies to address avoiding difficult conversations (e.g., including managers in training to address cultural issues).
3. Professional practice needs to account for the time required for planning and having difficult conversations, as well as gaining wider system understanding and support.
4. A simple framework is needed that highlights different system attributes (e.g. individual, team, workplace, and organizational) and how these influence the capacity to have difficult conversation so that intervention strategies could better predict and incorporate higher risk situations.
5. Further research is required to understand the issue of "lacking insight," its impact on avoiding conversations, ways to address this issue, and ways to improve current perceptions about attitudes and behaviors.

The authors acknowledge that the best and most effective health-care teams have honest, hard conversations with each other early, often, and when needed; and they are not avoided. This study however, focuses on situations when conversations are avoided, so that in the future, difficult conversations will be a part of all health-care professionals' practice.

Limitations

Qualitative results are not typically generalizable or transferable. The study was small and interviews were conducted over a 2-week period with only 20 clinical supervisors working across Victoria. Therefore, the findings do not necessarily apply across multiple contexts. Invitations to be part of the interview process were also given out to clinical supervisors who had previously taken part in difficult conversations workshops. This workshop, however, included participants who were representative of a cross section of clinical supervisors in Victoria. We did ensure in our study however that we had a range of ages, gender, and different professions represented. The number of interviews was also stopped at 20 participants, when no new data or themes were emerging. That is, the number of participants was determined by saturation, rather than time or resources, in line with the method. Another limitation, or perhaps better seen as an opportunity for further research, would have been to conduct a separate convergent interviewing process for each of the different professions, allowing for more comparisons to be made between professions. However, this study allowed for multiprofessional issues to be explored.

Conclusions

Health-care professionals need to embrace difficult conversations to reduce AEs and enhance patient outcomes. This requires additional training and educational opportunities to enhance knowledge, skills, and confidence to plan and engage in difficult conversations. Some types of difficult conversations require more skills than others. This study revealed that the main reasons for avoiding difficult conversations were fear of negative consequences, a general distaste for confrontation, and a lack of confidence in their skills to have such conversations. Additional factors included available time, individual qualities such as personality type, communication styles, and a range of perceived cultural barriers standing in the way of having difficult conversations. Whether the conversation was with a senior, peer, or junior was also important. Conversations about attitudes and behaviors were also found to be more difficult than those about clinical skills, particularly when the person lacks insight

about their own behavior or attitude, and therefore more likely to be avoided.

Convergent interviewing allowed for more in-depth and systemic understanding than previous studies about why health professionals avoid conversations and why some conversations are more difficult than others. Without the development of deeper level questioning, the finding that conversations about a change in attitudes and behaviors were more difficult than conversations about clinical skills would not have been uncovered. This was also the case for uncovering the diverse cultural issues and the issue of lacking insight and its impact on avoiding difficult conversations. This study provided a rich source of data from the daily lives of health professionals, particularly clinical supervisors and students in the Australian Health Sector. It can confidently be concluded that more research and training are needed on overcoming difficult conversations between all health professionals.

Declaration of Conflicting Interests

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