



RESEARCH BRIEF



# SILENCE KILLS 2.0

How Communication Failures Stifle  
Innovation and Harm Patients



AMERICAN  
ASSOCIATION  
of CRITICAL-CARE  
NURSES



# Silence Kills 2.0

## HOW COMMUNICATION FAILURES STIFLE INNOVATION AND HARM PATIENTS

A needle broke off inside a patient's chest wall during a procedure with a thoracic surgeon known to be short-tempered. The needle fragment was visible on x-ray, but when the surgeon couldn't retrieve it after multiple attempts, they became belligerent and said, "That's it, I'm leaving it." The technician expressed confidence in the surgeon then suggested inserting a spinal needle to pinpoint the location, then use the needle as a guide to retrieve the fragment. The surgeon nodded approvingly and successfully removed it. Before leaving, the surgeon said, "Thanks for helping me do the right thing." Staff who witnessed the exchange marveled at a side of the surgeon they'd never seen.



Healthcare is a human system. Delivering the best evidence-based treatment to patients requires seamless coordination across dozens—if not hundreds—of highly trained but imperfect humans. Millions of lives are saved and suffering curtailed thanks to the skills and dedication of healthcare professionals. Yet while the industry attracts people with a deep commitment to service, evidence shows that the occurrence of even small eccentricities multiplied across fragile human connections can substantially harm patients—especially when the system is burdened by uneven experience, varied training, fatigue, egos, power differentials, and natural human friction.

Previous studies have found that adverse events due to avoidable mistakes affect as many as one in three hospital stays.<sup>1</sup> Whether looking at successes or failures, one thing is clear: healthcare excellence is inextricably tied to the health of its human delivery system.

*"I was caring for a really sick man, who had diabetes and was complaining of nausea. He had a colon resection with a big incision. I noticed the sutures were separating and some of the staples had blown out. The surgeon on call that night declined my request to come see the patient and told me to just reinforce the dressing. The patient threw up and popped the stitches. His organs lay all over the bed and he died. It's hard to convince a physician when all you have is your instinct and no hard data."* -Nurse

In 2005, the American Association of Critical-Care Nurses (AACN) and Crucial Learning, a social science research and instructional design consultancy, conducted a study involving 1,700 clinicians, including nurses, providers, and leaders, to examine the relationship between communication and healthcare safety. The resultant report, *Silence Kills: The Seven Crucial Conversations for Healthcare*,



found that how caregivers act during a handful of common but crucial moments in various care settings strongly relates to both patient safety and patient experience, as well as to nurse and physician engagement.

## The Seven Crucial Conversations for Healthcare

### 1. BROKEN RULES

Between 62–84 percent<sup>2</sup> of caregivers regularly saw coworkers take shortcuts that could be dangerous to patients.

### 2. MISTAKES

Between 65–92 percent of caregivers worked with people who frequently made mistakes that could affect patient outcomes.

### 3. LACK OF SUPPORT

53 percent of caregivers worked with colleagues who often refused to help when needed.

### 4. INCOMPETENCE

Between 53–81 percent of caregivers had concerns about the competency of some nurse or other clinical-care provider they worked with; 68 percent of physicians and 34 percent of nurses and other clinical-care providers had concerns about the competency of at least one physician they worked with.

### 5. POOR TEAMWORK

88 percent of caregivers had one or more teammates who behaved divisively.

### 6. DISRESPECT

77 percent of caregivers worked with some who were condescending, insulting, or rude. 33 percent worked with a few who were verbally abusive—yelled, shouted, cursed, or name called.

### 7. MICROMANAGEMENT

52 percent of caregivers regularly experienced abuse of authority—pulling rank, bullying, threatening, or forcing their point of view on them.

While the study found these situations to be highly consequential—affecting morale, patient care, safety, and so on—fewer than 10 percent of respondents reported fully confronting their colleagues when they experienced one of them. Past research by Crucial Learning suggests that one of the most immediate consequences of a culture of silence is the persistence of these problems. The *Silence Kills* study found that in organizations where silence is the norm, issues with competence, breaking rules, and mistakes often persist for years.

## TWO NEW QUESTIONS

*Silence Kills* was not the only study to expose the impact of communication failures in healthcare. It was released on the heels of a study published by the Joint Commission on Accreditation of Healthcare Organizations that found communication failures were implicated at the root of over 70 percent of sentinel events.<sup>3</sup> These and other startling studies launched a concerted effort from regulatory bodies and individual organizations, including the authors of the study, to develop programs to improve communication practices in healthcare.

Shortly after *Silence Kills*, AACN issued the first national Standards for Establishing and Sustaining Healthy Work Environments. Healthy Work Environments (HWEs) have become the association's signature strategic initiative, anchored by six evidence-based standards that foster positive work environments for patients and clinicians. Meanwhile, Crucial Learning has advised hundreds of healthcare organizations on building cultures of candid dialogue.

On the twentieth anniversary of *Silence Kills*, AACN again partnered with Crucial Learning to answer a concerning question: Given the tremendous investment of resources since 2005, does silence still kill?

We engaged some of the most respected health systems and associations in the country to participate in data collection.



The resulting study, *Silence Kills 2.0: How Communication Failures Block Innovation and Harm Patients*, shares data gathered from more than 3,500 clinicians, including nurses, providers, and leaders.

We first asked the same survey questions as the 2005 study to compare findings with previous data. Specifically:

1. Have patterns of silence in the face of emotionally and politically risky concerns changed in healthcare in the past 20 years?
2. Has the relationship between candor about crucial issues and healthcare outcomes (such as nursing engagement, patient safety, physician satisfaction, nursing attrition, and patient satisfaction) changed? If so, how?

## A THIRD QUESTION: DOES SILENCE KILL INNOVATION?

This study extended the 2005 version to better inform future healthcare success. It explores whether Crucial Conversations substantially affect how quickly and effectively organizations adopt new evidence-based discoveries. While the previous study largely investigated the social processes that enable patient care errors, we gave equal emphasis to omissions—situations where a patient fails to receive the best evidence-based care possible. For example, a 2003 *New England Journal of Medicine* (NEJM) report suggested that the typical patient received 54.9 percent of scientifically indicated care.<sup>4</sup>

Thus, the study explored whether we are still struggling to adopt best practices in the present day, especially with new discoveries from artificial intelligence (AI) and machine learning?

### *Behavioral Agility*

Today, many argue excitedly that AI and machine learning will transform healthcare by consuming massive patient data sets and identifying treatment protocols that will outperform current practices. If the NEJM report holds true, the limiting factor in improving healthcare outcomes is not just identification of new knowledge, but a factor we call behavioral agility: the capacity of human healthcare systems to absorb and take action informed by that knowledge.

For example, maternal and fetal mortality are two enduring threats in healthcare. One common practice to spot early signs of distress is to apply a fetal heart rate strip to both pregnant mother and baby, and monitor for concerning variations. Historically, nurses and physicians have evaluated risk on a simple three-point scale where category 1 means all is well, category 3 indicates emergency, and category 2 is everything in between.

The 2 scores turn out to be a very large and often subjective category. This leaves a great deal of room for subjective interpretation, overuse of category 2, and widely differing communication practices when describing category 2 status. For example, a nurse can observe heart rate decelerations from a baby for a couple of hours and make no call because they assume the pattern is normal for labor. Fetal bradycardia can produce distress within that subjective window when potentially life saving intervention is delayed.



AI is being tested as a tool for discerning important nuances in category 2 scores. Early findings suggest both mothers' and babies' lives can be saved when AI identifies early warning signs of escalation in what would otherwise be treated as an undifferentiated category 2 score.

**HOWEVER, THESE AI DISCOVERIES WILL NOT SAVE LIVES IF:**

- A busy nurse fails to check readings at precise intervals.
- AI identifies potential emergent concerns that conflict with a caregiver's interpretation of the situation.
- The physician or midwife on call gets prickly when called for non-emergencies at night so the nurse waits before acting.
- A nurse records readings out of habit on a notepad, then inputs the data when they have a calm moment.

In each of these examples, the benefit of technology is nullified by a lack of behavioral agility. As AI and machine learning continue to be implemented in healthcare, the challenge may not be figuring out what to do, but how to translate these insights into new treatment patterns. New knowledge is useless without the new behavior needed to capitalize on it. *Silence Kills 2.0* explores the relationships between workplace candor and behavioral agility—likely the strategic cultural differentiator in the future of healthcare. Specifically, we asked:

1. Are there significant variations from team to team in capacity to adopt new evidence-based practices?
2. Are patterns in handling specific Crucial Conversations related to speed of adoption?

Thirty-five years of Crucial Learning research across every major industry has shown that the health of most any social system is highly related to the lag time between when problems are encountered and when problems are fully discussed and resolved. This study presents an opportunity to examine the relevance of this insight for a host of healthcare challenges.



## THE STUDY

Study sponsors included AACN and Crucial Learning. Participating data collection partners included (in alphabetical order) AARP, American Organization for Nursing Leadership, Emergency Nursing Association, legacy Jefferson Health System, Kaiser Permanente, LA General Medical Center, and Novant Health. Physicians, nurses and other clinical staff employed by, or who are members of, these organizations were invited to complete the online survey instrument between November 2024 and April 2025. Of 5,163 individuals who responded to the survey, 3,500 provided complete data across all survey questions and were included in our analysis.

**THE SURVEY INSTRUMENT INCLUDED ITEMS RELATING TO:**

1. Demographic data to allow same-unit comparisons as well as variations in experiences between various providers and levels of responsibility.
2. Items serving as proxies for clinical outcomes, including quality, safety, and patient



experience. Two self-report questions were also used to measure employee engagement and intent to stay or quit.

3. Frequency of encountering and response to the seven Crucial Conversations from the 2005 study. *Silence Kills 2.0* included an eighth Crucial Conversation: awareness and influence of bias.
4. Subjects' perception of the speed and consistency with which a unit identifies and adopts evidence-based practices.
5. Crucial Conversations hypothesized to be related to rapid and effective adoption of innovations identified in previous structured interviews.

Based on the large and diverse respondent base across these nine healthcare systems and associations, our findings offer critical insights into the dynamics of communication, behavioral agility, and outcomes in clinical environments.

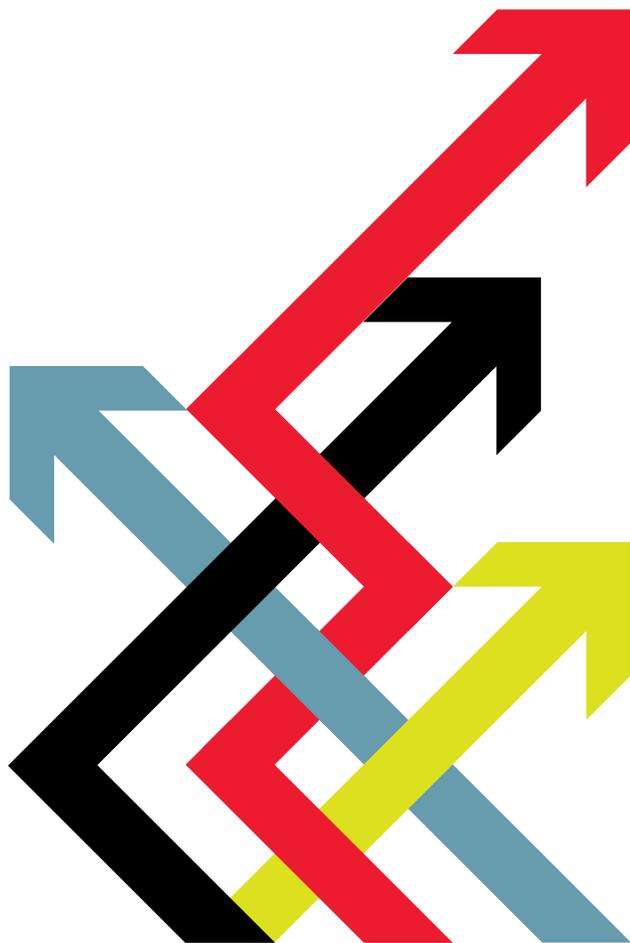
### ***Finding #1—Does Silence Still Happen?***

In brief, yes, but fortunately not as often. Encouragingly, the study found that healthcare workers speak up more frequently than 20 years ago. Whereas the 2005 study found that, on average, less than 10 percent of subjects spoke up across seven crucial moments<sup>5</sup>, in 2025, 32 percent of subjects on average are speaking up directly and airing their concerns. The needle has moved and progress appears to have been made.

With that said, we have a long way to go. *Silence Kills 2.0* found that 40 percent of healthcare workers report they still witness broken rules at least weekly or more, and 22 percent witness outright mistakes in patient care at least weekly (see Table 1). Of those who witness these issues, only about half directly confront the offender and completely express their concerns: 47 percent for broken rules and 53 percent for mistakes (see Table 2). The Crucial Conversations that healthcare workers are least likely to fully address include (see Table 2):

1. **Micromanagement** – only 13 percent will fully confront the team member
2. **Bias** – only 20 percent will fully confront the team member
3. **Poor teamwork** – only 27 percent will fully confront the team member
4. **Disrespect** – only 30 percent will fully confront the team member
5. **Lack of support** – only 31 percent will fully confront the team member

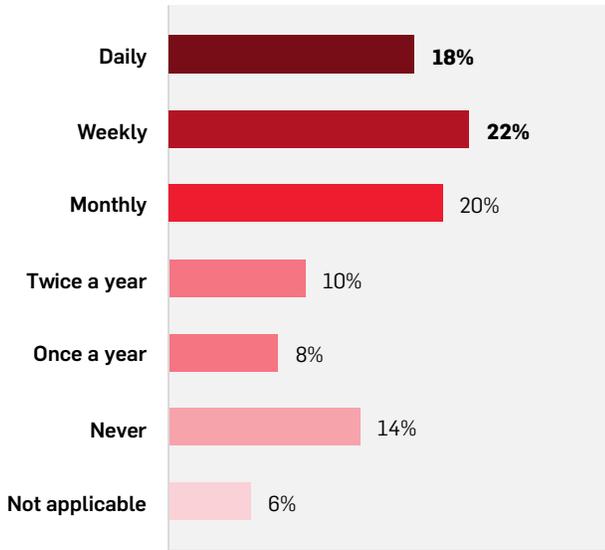
The silence and fear implied in these results indicate substantial missed opportunities to correct unsafe and unproductive behaviors. Reliability of the human healthcare delivery system still varies widely from hospital to hospital and success still hinges on the ability to consistently and effectively engage in dialogue that could save lives.



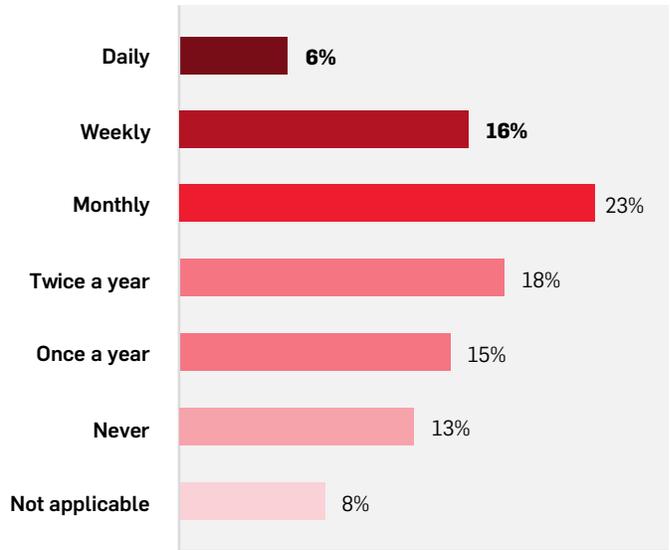


**Table 1: How Often Healthcare Workers Witness Eight Crucial Moments**

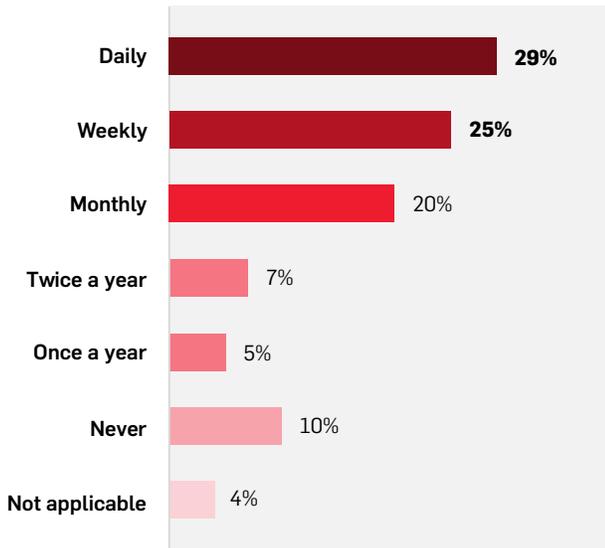
**BROKEN RULES**



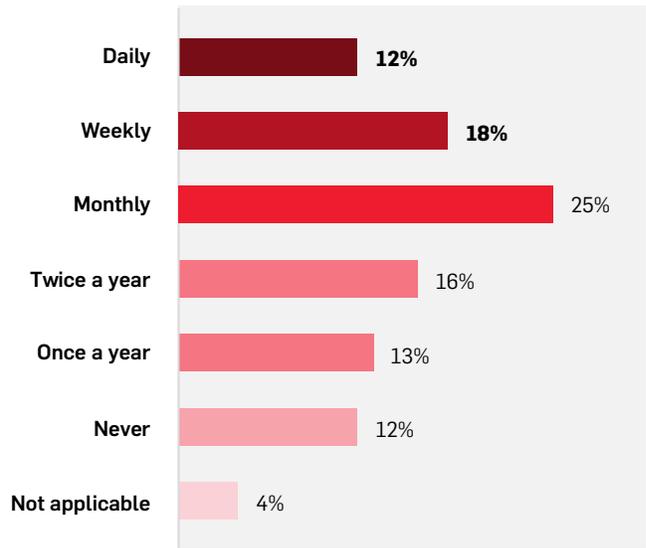
**MISTAKES**



**LACK OF SUPPORT**



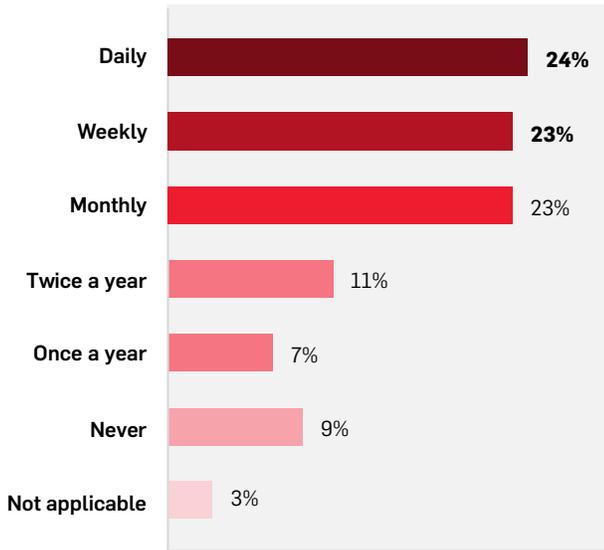
**INCOMPETENCE**



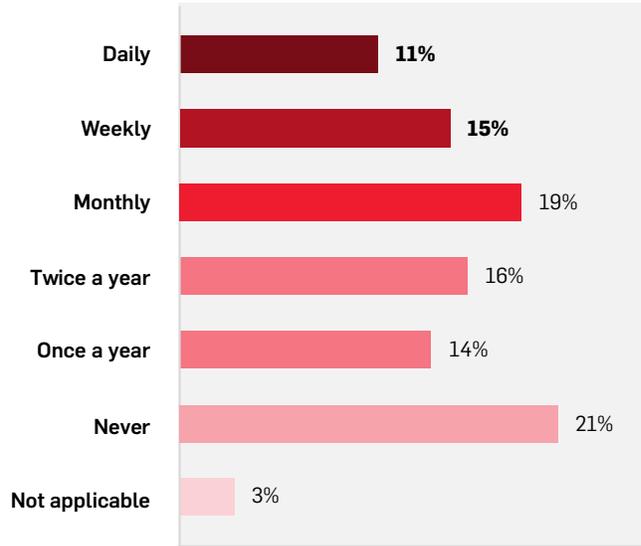
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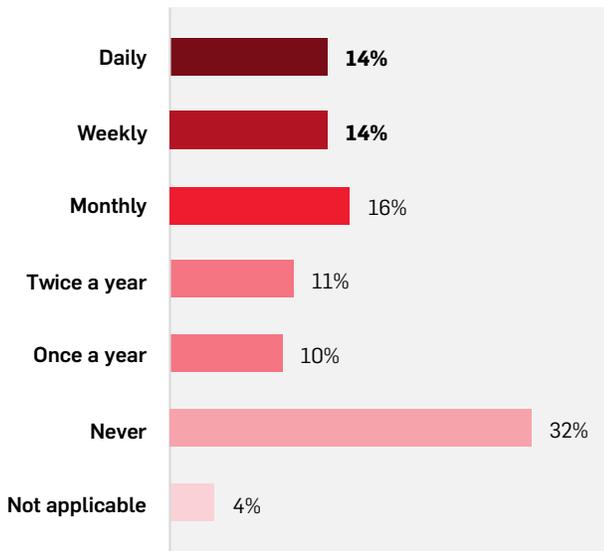
## POOR TEAMWORK



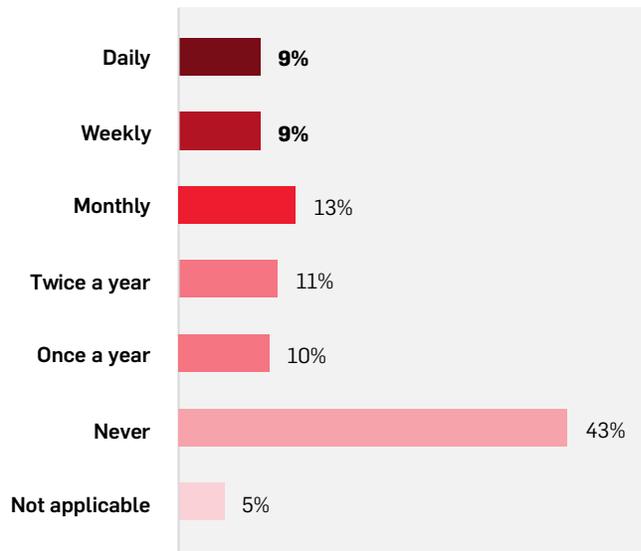
## DISRESPECT



## MICROMANAGEMENT



## BIAS

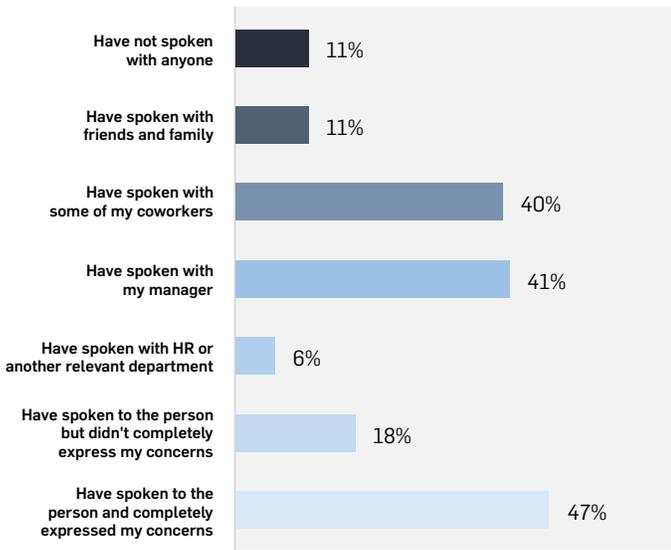


HOW OFTEN WITNESSED	BROKEN RULES	MISTAKES	LACK OF SUPPORT	INCOMPETENCE	POOR TEAMWORK	DISRESPECT	MICRO-MANAGEMENT	BIAS
<b>Net:</b> At least weekly	40%	22%	54%	30%	47%	27%	28%	18%
<b>Net:</b> Witness	79%	79%	86%	84%	88%	76%	64%	52%

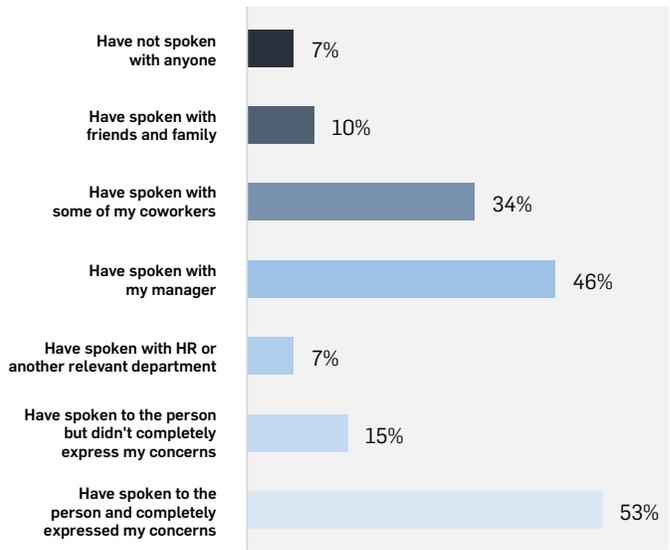


# Table 2: Percentage of People Who Effectively Spoke Up in Eight Crucial Moments

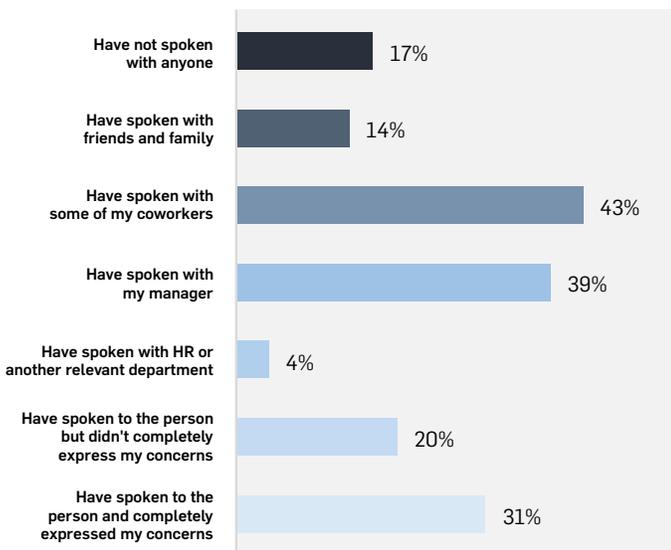
## BROKEN RULES



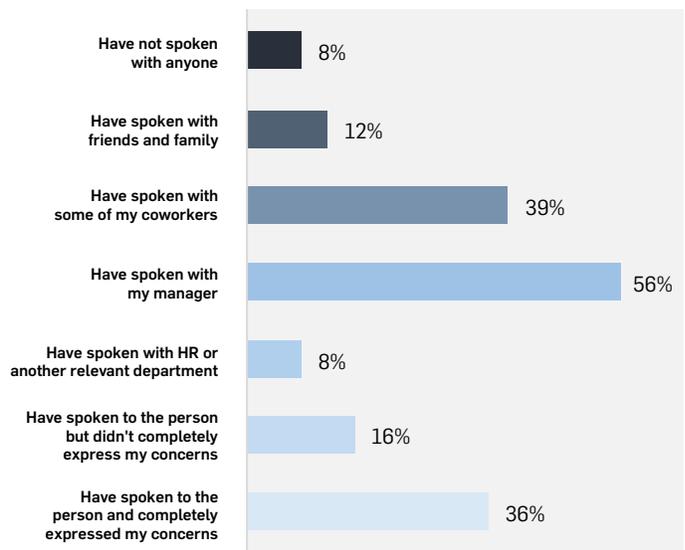
## MISTAKES



## LACK OF SUPPORT



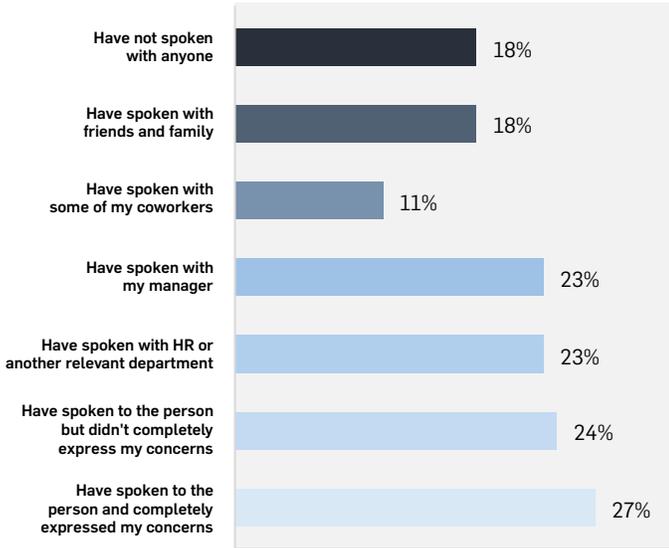
## INCOMPETENCE



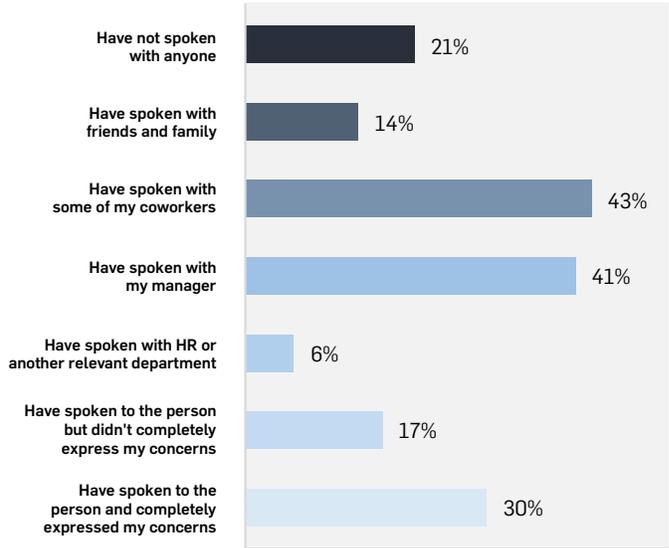
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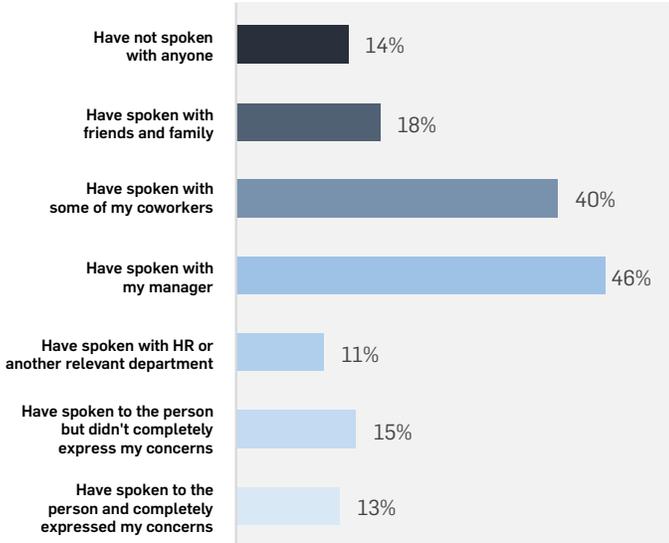
## POOR TEAMWORK



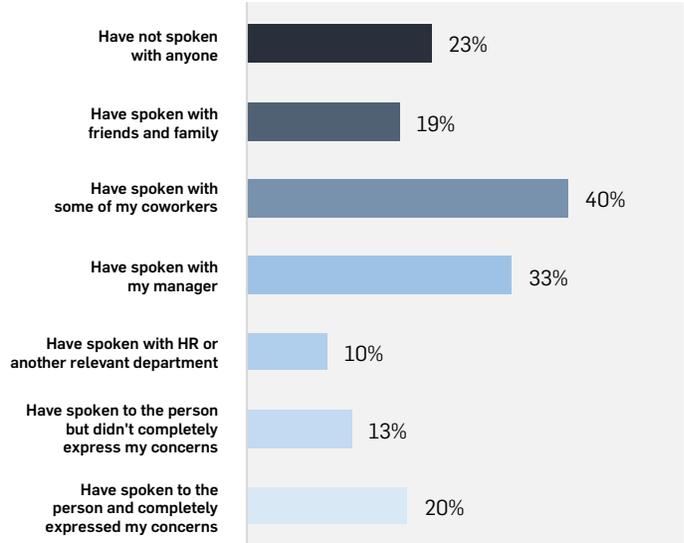
## DISRESPECT



## MICROMANAGEMENT



## BIAS





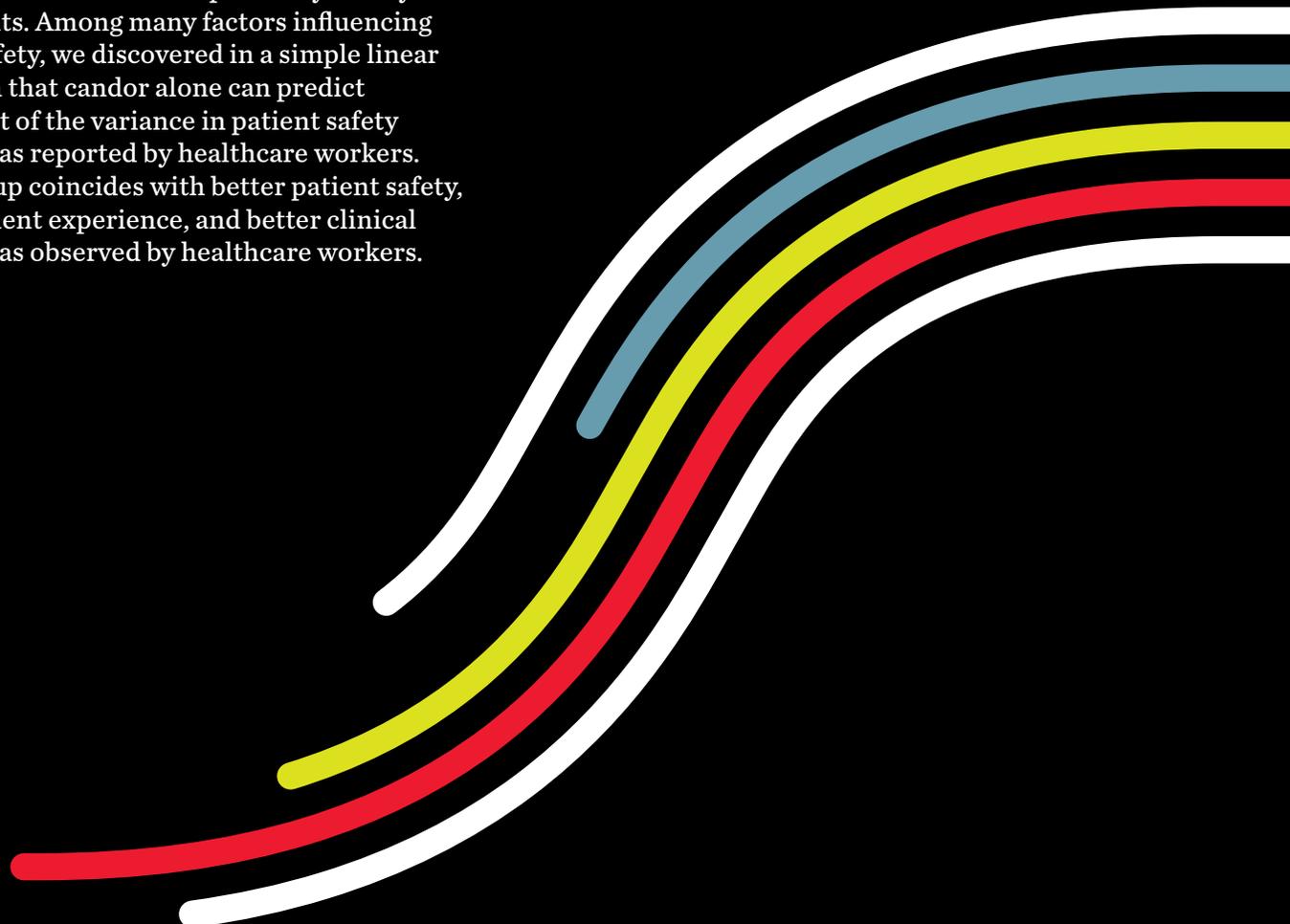
## *Does Silence Still Kill—And Affect Other Crucial Outcomes?*

The original *Silence Kills* study found a correlation between better patient outcomes, as reported by healthcare workers surveyed, and those who expressed concerns. Specifically, data showed that the 10 percent of healthcare workers surveyed who reported that they raised crucial concerns also reported observing better patient outcomes, worked harder, were more satisfied and were more committed to staying in their job.

*Silence Kills 2.0* found that the correlation between speaking up and better patient safety, patient experience, and clinical outcomes as observed by healthcare workers remains strong. Speaking up in every instance has a correlation of 0.18 correlation with clinical outcomes and on a 5-point scale is associated with a 0.379 point improvement in clinical outcomes. Regression analysis further shows that speak-up behavior is significantly related to improved outcomes as reported by survey participants. Among many factors influencing patient safety, we discovered in a simple linear regression that candor alone can predict 3.5 percent of the variance in patient safety outcomes as reported by healthcare workers. Speaking up coincides with better patient safety, better patient experience, and better clinical outcomes as observed by healthcare workers.

Which conversations matter most? Mistakes and bias are conversations with the biggest reported association with clinical outcomes, followed by broken rules and incompetence. Not surprisingly, conversations with the most significant association to patient safety involve mistakes, broken rules, incompetence, and disrespect.

The study also found that those who fully confront issues whenever they arise report 12 percent higher patient safety and 11 percent better clinical outcomes than individuals who do not fully confront issues. This is also associated with 16 percent higher employee engagement and 12 percent better employee retention—all statistically significant improvements.





Speaking up isn't just good for patient outcomes. It also impacts turnover and engagement. At a time when nursing turnover has become a primary strategic and operational concern for hospitals, our research found a clear relationship between subjects speaking up, their intention to stay, and their level of engagement in their work. Specifically, those who fully speak up at crucial moments report a 30 percent lower likelihood of looking to leave their organization within the next six months than employees who do not speak up at crucial moments. Conversely, those who are less likely to speak up also report giving less energy and effort at work than they are capable of giving (Pearson correlation 0.134). Fully confronting issues whenever they arise is associated with a 0.432 point improvement in employee engagement and 0.401 point improvement in employee retention on a 5-point scale.

Unsurprisingly, healthcare workers who directly confront the eight crucial moments measured tend to be employed by organizations with a self-reported strong culture of candid

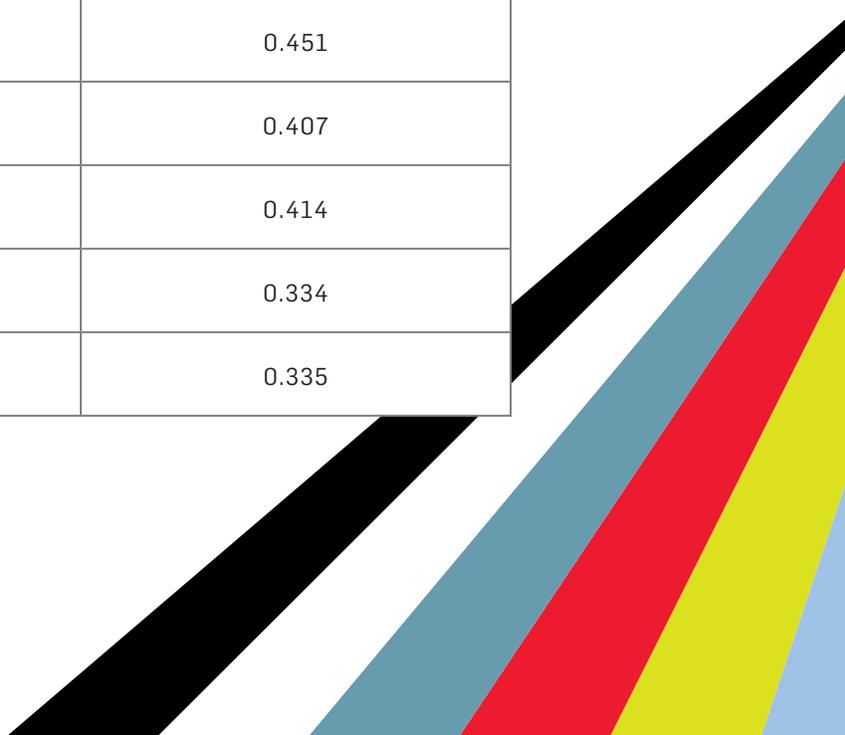
communication—as measured by proxy items. Organizations with a broad culture of accountability, reminding, challenging assumptions, and speaking up have nearly twice as many healthcare workers who will directly confront the eight problems we tested. These are healthcare organizations that consistently follow the principles of high-reliability organizations.

Comparing outcomes between these organizations with a reported broader culture of candor renders even more striking impacts on patient and employee outcomes. These organizations are significantly more likely to also report better patient safety, patient experience, and clinical outcomes in addition to high staff retention and engagement (see Table 3).

Speaking up continues to be the vehicle for shaping norms that govern behavior from one hospital to the next. Conversely, failure to speak up overtly indicates an absence of healthy norms.

**Table 3: How Speaking Up Impacts Turnover and Engagement**

RELATIONSHIP BETWEEN CULTURE OF CANDOR AND OUTCOMES	PEARSON CORRELATION COEFFICIENTS
Patient safety	0.451
Patient experience	0.407
Clinical outcomes	0.414
Employee retention	0.334
Employee engagement	0.335





## Finding #2 – Does Silence Kill Innovation?

*“One provider prescribed a drug that [new research] showed worked best if administered three times a day. And yet, the provider told me to do it twice a day. I did it the provider’s way.” –Patient*

This study found that the hypothesized relationship between a culture of candid communication and the capacity to absorb new technology and practices is strong. The speed with which new behavioral norms are adopted—the level of an organization’s behavioral agility—is profoundly related to team members’ willingness and ability to address four Crucial Conversations:



### 1. SPEAKING UP

Openly point out concerns that indicate a need for innovation.

*“I’m a nurse in a hospital that uses QPRT to identify risk factors for patients in our behavioral care unit. After repeated instances of psychiatrists discharging patients in spite of risk indications from the tool, I raised the concern with other team members. Shortly thereafter a patient attempted suicide after discharge when QPRT would have called for further in patient treatment. In spite of our fear of offending psychiatrists, we agreed to begin gathering compliance data to help us improve.”*

### 2. REMINDING

Nudge colleagues when they default to past routine instead of improved methods.

*“Our team is often pressed for time. In order to help us remember to use a new and more rigorous evidence-based app for assessments, we agreed to give a “shaka” sign to each other when it might be tempting to do it the old way.”*

### 3. HOLDING EACH OTHER ACCOUNTABLE

Offer direct and immediate correction if someone violates best practices or agreed-upon behavioral norms.

*“I noticed the surgeon marking the wrong foot for surgery while having a social conversation with the patient. I reminded the surgeon that our protocol was no cross-talk during the pre-surgical checklist process. They complied, then abruptly noticed that they had marked the wrong foot. They scrubbed off the marking from the incorrect site, marked the correct one, then nodded at me. They have been much more careful since this experience and our relationship has been strengthened.”*

### 4. CHALLENGING ASSUMPTIONS

Follow the data irrespective of ego or habit.

*“In past meetings an older doc had a habit of saying things like, ‘That bucket of bolts never met one of my patients’ when we’d discuss insights offered by our data scientists. One day a senior partner said, a bit testily, ‘Can we agree that from today forward, data trumps aphorisms at this table?’ It was tense for the rest of the meeting, but our conversations have improved.”*



A healthcare system’s capacity to implement new knowledge is related to its clinicians’ motivation and ability to have these conversations at a very strong and statistically significant level. A culture of candid communication has an impressive Pearson correlation of 0.712 with behavioral agility.

**ORGANIZATIONS IN THE TOP DECILE OF HOLDING THESE FOUR CONVERSATIONS**

- Have **20 times as many** healthcare workers who report they fully implement ideas for using new tools and technology “quickly” or “immediately” than less candid teams.
- Report **2.5 times higher** proactivity in looking for ways to improve patient outcomes and quality of care.
- Adopt new clinical practices at more than **2 times the rate** as organizations in the lower deciles.

Organizations with team members who feel safe and empowered to have these conversations not only increase their behavioral agility—demonstrated by adoption of new best practices—they also experience added bonuses that come from speaking up. It is no coincidence that the most behaviorally agile organizations fully confront problems at nearly twice the rate as the least agile (on average, 47 percent of cases versus 26 percent of cases).

**OTHER KEY FINDINGS INCLUDE:**



89 percent of top candor teams feel more empowered to propose new, more effective practices for their unit compared to 32 percent among lower performers.



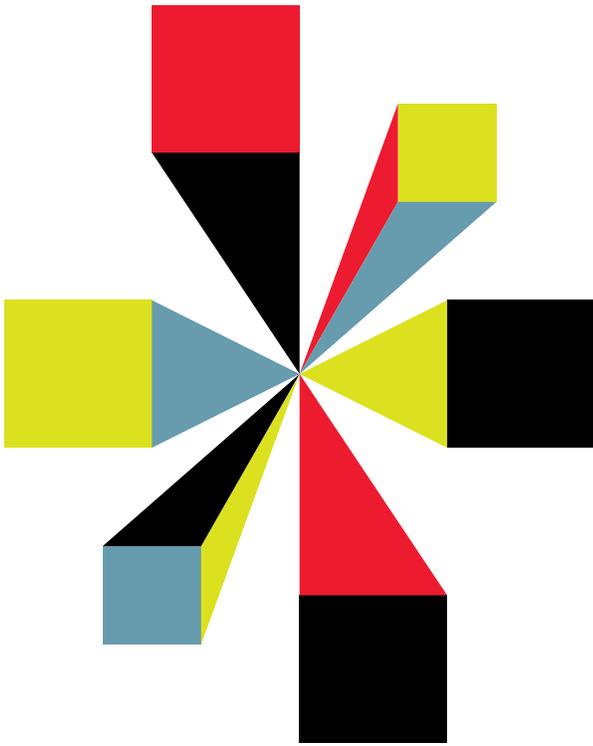
Lower-scoring teams are 314 percent more likely to feel cynical and powerless, recognizing opportunities for improvement but taking little action to implement them.

## CONCLUSIONS & RECOMMENDATIONS

The healthcare industry attracts highly trained and deeply committed individuals who work tirelessly to produce great outcomes every day. However, it is no surprise that a human system as complex, stressful, and integrated as healthcare delivery would be imperfect. Many failures are idiosyncratic—disappointing outcomes caused by a perfect and unpredictable storm of human, technological, patient, social, ecological, and other factors.

Other failures, however, are not. Many are due to discernible patterns of silence in a handful of crucial moments. There is hope in this study’s assertion that if leaders can create cultures where caregivers are both motivated and able to speak up in these common but costly situations, significant improvement is possible both in the short and long term. Short term, if more work is done to create cultures of candor in the eight Crucial Conversations described above, better patient outcomes and patient experiences are likely to follow. Long term, the pace of adoption of breakthrough ideas and technology appears more likely when leaders influence teams to routinely speak up about the four Crucial Conversations that drive rapid adoption of new practices.

Even more hopeful is this study’s evidence that marked progress has already been made. If we have experienced dramatic improvement in creating cultures of candor over the past 20 years, we can continue to accomplish additional improvement during the next 20. Furthermore, the wide variation in candor levels in organizations involved in this study bolsters confidence that leadership matters. It need not take two decades to improve cultural strength. Past research by Crucial Learning suggests that dramatic improvements in large-scale organizational behavior can be achieved in a matter of months.<sup>6</sup>



Many of the healthcare organizations in this study have employees with pent-up desires to create positive change. Forty-five percent say they have more energy, effort, and creativity to offer at work than they are currently invited or allowed to give. What is needed to unleash this potential energy is a culture that empowers them to challenge current norms. There are people at work in almost every organization right now who see problems and have ideas but are inured in silence.

The reluctance to speak up is so deeply rooted in the healthcare culture that it will take serious effort to create lasting improvements. AACN points out that lasting change in challenging interpersonal communication practices like these will require the combined commitment of nurses and healthcare professionals as well as healthcare organizations.<sup>7</sup>

The good news is that change is possible. This study documents that healthcare workers are now nearly three times more likely to speak up than they were two decades ago. Clearly, this is the result of many sources of influence. But work by Crucial Learning has found that a handful of potent interventions can accelerate positive improvement.

## *Measure It Like It Matters*

The fundamental principle of organizational attention is this: If you don't measure it, you don't care about it. Survey your hospital or system to establish a baseline measure of these aforementioned Crucial Conversations and set a clear target for improvement. A public goal for 25 percent improvement in a one-year period is achievable and will concentrate attention on the issue. Update the baseline at least four times a year so people can be rewarded and held accountable for progress.

## *Create Motivation*

The 2005 *Silence Kills* study was used by tens of thousands of healthcare leaders to draw attention to the problem of silence. The hope is that this one renews that call to action. Leaders can use this new study to provoke discussion and reflection in their organization. They will be more effective at doing so if armed with site-relevant data they've collected, demonstrating these findings' relevance to their teams.

However, data and studies aren't enough to change hearts and minds. Add stories. Leaders should seek out stories from their own organizations that personalize key findings of this report. Stories connect people with the human consequences of their actions.

## *Address Ability*

Most people fail to speak up because they can't imagine how to do so in a way that won't provoke problems. In other words, they don't simply lack motivation, they lack ability.

Most efforts to improve ability achieve little because they fall far short of the "Who, What, How and When" of guided mastery.

- **Who: Leaders must teach.** Technical skills can be taught by anyone with sufficient competence. Social skills that call on people to challenge current norms must be taught by those with sufficient credibility. To create a culture of candor, leaders must teach. Research shows that line managers, even those selected for their poor teaching abilities, achieve greater improvements than highly rated professional trainers.<sup>8</sup>



In addition, having a leader teach a set of skills guarantees he or she will master them, and goes a long way toward ensuring he or she will “walk the talk” and model the skills. The role of hierarchy in patterns of silence warrants further exploration since study data indicated individuals least likely to speak up hold less senior roles and have shorter employment tenure.

- **What: Deliberate practice of proven skills.** Training must employ effective instructional design—meaning that the majority of time is spent in hands-on practice of specific skills in relevant scenarios with immediate coaching and feedback. The technical term for this is “deliberate practice.” The skills taught should be valid in the highly emotional and risky confrontations we’re asking people to step up to. Generic training in communication will not suffice when these eight emotionally and politically risky topics emerge. In addition, the training activities need to include emotionally compelling experiences that cause participants to examine themselves and recognize the need to change.<sup>9</sup> Finally, they need to spend most of their time *doing it*—not *talking about it*.
- **When: Spaced learning.** Smaller chunks spaced a week or two apart are far better than longer, more intensive chunks. Two-hour or four-hour workshops avoid the cognitive overload so common in many

training programs, and spaced learning allows people to apply and test the skills between sessions. Training scheduled for logistical convenience rather than human change leads to little human change.

- **How: Sustained attention.** Some training interventions seem like a race to the finish—as if the goal is to get everyone through the course as quickly as possible. In fact, sustaining a skill-building effort over time is more important than finishing it on deadline. Unless people stay in the learning process for four to six months, it won’t penetrate to their daily experience. If the goal is to change your human system, continuous effort must be invested in helping people overcome a natural tendency toward silence and avoidance.

Rapid, profound, sustainable behavior change is possible if leaders lead. And after all, what is leadership other than intentional influence? Leaders aren’t those who produce results. Leaders influence others to improve results. They help a group of imperfect people accomplish extraordinary things. And never has leadership been more needed in healthcare than it is today.





## ENDNOTES

- 1 *Health Aff (Millwood)*. 2011 Apr;30(4):581-9. doi: 10.1377/hlthaff.2011.0190. "Global trigger tool' shows that adverse events in hospitals may be ten times greater than previously measured." <https://pubmed.ncbi.nlm.nih.gov/21471476/>
- 2 *The range represents differential responses from doctors, nurses and other clinicians.*
- 3 *Joint Commission on Accreditation of Healthcare Organizations. National Patient Safety Goals. 2005. [Accessed February 6, 2008]. Available at: [www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/](http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/) [PubMed] [Reference list]*
- 4 *New England Journal of Medicine* 2003; 348: 2635-2645 (June 26, 2003). Medical records for 6712 patients found that participants received an average of 54.9% of evidence-based care. Acute interventions were received 53.5% of the time; chronic interventions 56.1% as often as indicated; and preventative interventions 54.9% as often as indicated. The "defect rate" in the technical quality of American healthcare was found to be approximately 45%.
- 5 *The eight crucial moments include the original seven from the 2005 study plus occasions where caregivers witness bias due to education, experience, race, gender, sexual orientation, age, etc.*
- 6 *See, for example, Crucial Influence: Leadership Skills for Lasting Behavior Change, pages 11–14.*
- 7 *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence Association of Critical Care Nurses: (2005) 40.*
- 8 *Crucial Learning's research on using leaders as teachers.*
- 9 *For information on Crucial Learning's approach to Crucial Conversations, [CrucialLearning.com/healthcare](http://CrucialLearning.com/healthcare).*

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### AACN

*For more than 50 years, the American Association of Critical-Care Nurses (AACN) has been dedicated to acute and critical care nursing excellence. The organization's vision is to create a healthcare system driven by the needs of patients and their families in which acute and critical care nurses make their optimal contribution. AACN is the world's largest specialty nursing organization, with about 130,000 members and nearly 200 chapters in the United States.*

