



Silence Kills

Exploding Shuttles, Media Meltdowns, and Health Care Disasters. What's the Underlying Cause?

By Joseph Grenny

What do Columbia, HealthSouth, New York Times, Enron, Tyco, Worldcom, Duke University, and Baylor University Hospital all have in common? All experienced major organizational disasters in the past year. And all could have avoided these disasters if they had paid attention to one key attribute of their cultures: the way in which they manage crucial conversations.



How people habitually handle crucial conversations is one of the most reliable predictors of both organizational effectiveness and, conversely, organizational disaster.¹ The organizations cited above are cases in point. In each, leaders allowed a “culture of silence” to exist that made the consequent disasters all too predictable. None of these disasters happened overnight. And the precursors to each of them were witnessed by hundreds—even thousands—who noticed but said *nothing*. Why?

Silence in the face of potentially crucial conversations—conversations in which the stakes are high, emotions run strong, and there are sharply opposing viewpoints—is typically the path of least resistance in any organization. Unless leaders go to extraordinary lengths to counter the tremendous natural pressure that people feel to remain silent, disaster is inevitable. The insult added to the heinous personal and financial injuries inflicted by these and other organizational disasters over the past two years is that these consequences were not only predictable, but they were avoidable as well.

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For example, the death of the seven astronauts aboard the space shuttle Columbia on February 1, 2003, was the inevitable result, not of leaders who actively suppressed potentially embarrassing information, but of leaders who *failed* to foster a culture in which crucial conversations about potential risks could take place without the threat of reprimand or other serious repercussions. This terrible tragedy was also the result of oversight groups that failed to notice abundant warning signs about a culture that consistently suppressed crucial conversations.

Leaders who want to learn from the myriad leadership disasters of the past few years need to connect the dots. Those who do so will see clearly what they must do in order to avoid becoming the next inevitable headline. In what follows, we will call attention to some of the warning signs that should have been heeded, and to some of the missing crucial conversations that should have been held.

But the news is not all bad. In addition to describing how negative cultural habits of suppressing crucial conversations can predict disaster, we will also present a case study of where things went right—of an organization that created a culture that prized candor around such issues, and that prospered as a result.

“The inability to handle crucial conversations well or at all is the common thread in organizational failures today.”

Crucial Conversations Missing in Action

Accounting Scandals

The accounting disasters that took place at Worldcom, Enron, Tyco, and HealthSouth were not the result of bad leaders acting in isolation. These incidents required hundreds of passive accomplices who noticed irregularities but said *nothing*. For the fact is, corporate ethics are *not* maintained exclusively by saintly CEOs, but also by hundreds of other ordinary employees who are willing to step up and confront individuals when first they venture into ethically gray areas.

Such assertiveness was largely absent in the recent accounting scandals. For example, as early as 2002, Michael Vines, who managed assets for some 500 HealthSouth facilities in the West, had concerns about accounting practices at the company, including such clearly unethical activities as the falsification of invoices. And yet he and others who noticed these practices said *nothing*.

At Worldcom, as that once great telecommunication firm’s fortunes were rapidly sinking, competitor Verizon made a premium offer to take over the company.² But a culture of silence had become so deeply ingrained in the Worldcom Board of Directors that, when CEO Bernie Ebbers dismissed the offer without even inviting investment banking review, the Board said *nothing*.³ Indeed, the fiscal irresponsibility that sunk Worldcom was not that of even a select few. Rather, it required years of witting—and unwitting—collusion on the part of hundreds who noticed but stayed mute. Had the Worldcom Board monitored the quality of crucial conversations among its members and in key areas of the organization, it would have identified a cancer long before it spread beyond cure, even engulfing suppliers like Onvoy that (if recent reports hold true) colluded with Worldcom in illegally rerouting calls to avoid paying tolls to AT&T and others. In these and myriad other

instances, a culture of silence around legal or ethical concerns has created fertile soil for financial disaster.⁴

Health Care Tragedies

The recent deaths of Jessica Santillan at the renowned Duke University Medical Center and Jeanella Aranda at Baylor University Medical Center,⁵ resulting from carelessly mismatched blood types during organ transplants, illustrates the tragic results of silenced conversations on a more human scale. People who should have been aware of the blood-type mismatches simply said *nothing* rather than challenge doctors to follow the standard double-checking procedures. In acknowledging its failures, Duke University did offer a solution that, in part, recommended institution of a new procedure for *triple-checking* for compliance with required blood-types tests. Worthy as the motivation behind the proposal may have been, the policy neglected to deal with the root cause of such tragic disasters—namely, why nurses and fellow doctors did not hold each other accountable for existing policies that already required cross-checks to ensure the accuracy of blood types.

Why, we must ask, did the first two checks not reveal the failure to test for matching blood type? The answer, unfortunately, is that most health care workers operate in a culture in which silence is the preferred response when physicians violate protocols. Adding a third level of checks is a mere Band-Aid: it masks the problem, but does not cure it.

The tragedy, of course, extends far beyond Jessica Santillan and Jeanella Aranda. A culture in which health care workers fail to hold each other accountable contributes to some two million hospital-induced infections each year and results in tens of thousands of unnecessary patient deaths. For instance, a federal Centers for Disease Control and Prevention (CDC) study found that health care professionals wash their hands about half the number of times that policies require—a key factor in the spread of hospital-borne infections. The study probed whether redesigning the care environment through such physical remedies as making more sinks available would help doctors and nurses to wash their hands when they should.

The answer? It didn't. What mattered most was whether or not the senior doctor washed his or her hands. Period. When the lead person set a bad example, not only did nurses, residents, and others not speak up, they fell in line—and failed to wash their hands as well.⁶ In such a culture, adding double or triple checks is worse than pointless. It is actually damaging, because it diverts attention from the root cause of the problem: the failure of the organization's leaders to foster a culture in which crucial conversations can candidly and effectively addressed take place, regardless of the participants' position or tenure.

In the same way that hospital errors are routinely ignored, so too is physician incompetence most commonly handled by avoidance rather than confrontation. In incident after incident, we have witnessed how physicians working with incompetent partners try to protect patients' well-being by manipulating case assignments rather than by confronting the real problem—physician incompetence—head-on.⁷ In one hospital, for instance, six physicians stated flatly: "If Dr. X were on duty, I would drive to the next hospital rather than have him treat my child." Yet all six physicians were partners of Dr. X, and none had ever bothered to challenge him about his perceived medical incompetence.

But the problem goes even further. Not only do doctors and staff members too often stay silent when policies are violated or incompetence manifests itself, they shrink at times from challenging patients when they should. One researcher estimates that more 41 million times each year doctors issue antibiotic prescriptions to demanding patients suffering from colds—even though the antibiotics would

provide no benefit, and could even risk causing the patient to develop a future immunity to the drugs.⁸

Tough Times At The Times

Similarly, we get it wrong when we think removing one leader or one bad apple at the “Big Apple’s” premier newspaper will solve the New York Times’ journalistic ethics problems. The root cause of the recent Jayson Blair scandal (in which a young journalist fabricated reports from the field when he was, in fact, writing from the comfort of his apartment) was not just the blind eye of a self-deceived editor, but the psychological myopia of countless individuals at all levels of the Times who cowered from crucial conversations when their young colleague stepped over an ethical and moral line. The difference between healthy organizations and those that suffer massive failure is what happens when an individual witnesses an ethical or moral violation. In healthy organizations, individuals at all levels speak their minds and insist that they be heard. In less healthy organizations, people silence themselves—or are silenced by the authority of others—even when the problems are (or should be) apparent to dozens if not hundreds of others.

NASA “Chicken” and the Columbia Disaster

Perhaps the most tragic—and most predictable—recent example of the failure to undertake necessary crucial communications is the February 2003 Columbia Space Shuttle disaster. In the days following what seemed to be an unexceptional lift-off, Rodney Rocha, a chief structural engineer at NASA’s Johnson Space Center, determined along with several colleagues that the stray foam strike that had occurred seconds after the Columbia’s launch bore further investigation. Other engineers shared this concern, and so they asked that satellite photos be provided that would help them to probe the possibility of foam-induced damage.

Now, such photos are very expensive, and in a tight fiscal environment, few people want to be charged with spending money unnecessarily. So when Linda Ham, head of the mission management team, subsequently asked who it was who wanted to view the satellite photos documenting the foam strike, she was met with silence. *No one spoke up.* And so she declined to pursue the matter further.⁹ When Rocha later learned that Ham would not request the satellite photos, he drafted an email stating, “In my humble opinion, this is the wrong (and bordering on irresponsible) answer.” But he chose not to click the “Send” button. Again, *silence.*

What causes this “culture of silence”? There are some very obvious explanations. First, few people enjoy raising bad news. Many view such tasks as confronting a colleague, pointing out flaws, or raising product concerns with a considerable amount of dread. Second, organizational cultures often support or even actively encourage this silence. For example, NASA’s previous boss, Daniel Goldin, ruled with such an abrasive and punishing demeanor that, according to John Logsdon, head of George Washington University’s Space Policy Institute, “There were people afraid to tell Mr. Goldin things he didn’t want to hear.”¹⁰

In the years prior to Columbia’s tragedy, NASA’s leadership had made deep cuts in critical safety programs. Of course, every organization has to trim its costs at times. What keeps such cost-cutting from becoming dangerous is that managers will push back—and push back hard—when they view cuts as having potentially serious consequences. Under the atmosphere of forced silence that Goldin helped to create, however, that pushback never occurred.

It wasn’t for a lack of concern. As early as 1995, Jose Garcia, a shuttle operations manager, openly predicted the loss of another shuttle. When budget cuts began to put safety operations at risk, Garcia expected that those in the chain of command

above him would warn senior leaders that proposed cuts were so deep as to place future shuttle flights at serious risk. When they did not communicate these warnings, Garcia did. Unfortunately, when an isolated voice repeatedly complains from a berth deep down inside an organization, such concerns—absent confirming leadership support—are easily dismissed by those in authority.

As we have consulted with aerospace companies, we have repeatedly witnessed this tendency within the NASA universe to avoid crucial conversations. In fact, it is so prevalent that it even has a name: “NASA Chicken.”¹¹ It is a tendency to avoid addressing safety issues that might delay a project, in the hope that someone else from another division or another company might raise the issue, and thereby be blamed for pushing a project beyond its completion deadline. As that deadline looms ever closer, a growing number of people are waiting for others to voice concerns, while keeping their silence in order (they perceive) to keep their jobs. In a fashion similar to the dangerous and foolhardy driving game called “chicken,” it’s a matter of waiting to see who will blink first—and, when no one does, disaster predictably ensues.

Which is precisely what happened multiple times in the days leading up to the Columbia disaster. The unwillingness of people in critical positions to speak up about the risks presented by safety program cost-cutting, by the potential damage from foam strikes, and even by the turf wars between the Johnson and Kennedy Space Centers, allowed critical information to remain suppressed, and a fatally crippled Space Shuttle to re-enter the atmosphere on its way, not toward its expected landing, but toward unavoidable doom.

Creating a “Culture of Conversation”

The Lockheed Martin Example

Sometimes, organizations do respond to potentially damaging circumstances in a productive way. Such was the case with aerospace giant Lockheed Martin.¹²

When we began working with Lockheed Martin Aeronautics in August 1998, the company was in a fight for its corporate life. Lockheed’s future depended upon winning its bid to build the \$200 billion Joint Strike Fighter (JSF). With the long-running F-16 program approaching termination, Lockheed’s Fort Worth facility faced grim alternatives: either become the center for JSF production, or else cease to exist as anything more than a spare parts supplier for America’s aging F-16 fleet.

To prepare for this long battle, Lockheed committed itself to the kind of internal improvements that its leaders knew would be necessary to win—and deliver on—the JSF contract. Therefore, over a period of several months, Lockheed executives and VitalSmarts consultants taught, modeled, and tracked improvement in six specific crucial conversations that routinely transpired at Lockheed. In just nine months, Lockheed officials could demonstrate dramatic gains in survey measures of the quality of these conversations. Independent research conducted by Texas Christian University showed a strong correlation between improvements in these crucial conversations and significant gains in productivity, costs, and quality.

These gains were persuasive to federal contract administrators—and to Lockheed’s senior executives as well. When Lockheed Martin eventually won the JSF program in 2000, Dain Hancock, Lockheed’s president, declared that: “We now have hard evidence that [crucial conversations] drive our productivity, costs, and quality... and were essential to our winning the Joint Strike Fighter program...”

Are You Next?

Leaders and oversight groups don't need to lose much sleep wondering about whether their organization is next in line for membership in the Rogue's Gallery of high-profile failures.

They can know in advance.

They simply need to identify the kinds of conversations that are most crucial to achieving their mission's success, and scrupulously hold senior leaders accountable for developing a culture in which these conversations can take place every day.

Those organizations that succeed in holding crucial conversations and holding them well will not only find that they can generally avoid failure, but that they will also reap enormous boosts in performance—a result that will be unequivocally positive for all of the organizations' key stakeholders, from the most senior Board Member to the most junior employee.

¹ See Patterson et al., *Crucial Conversations: Tools for Talking When Stakes are High* (New York: McGraw-Hill, 2002), pp xx.

² Carrick Mollenkamp, "Accountant Tried In Vain to Expose HealthSouth Fraud," *The Wall Street Journal*, May 20, 2003.

³ *USA Today*, June 10, 2003, p. 3B.

⁴ Yochi J. Dreazen and Almar Latour, "Former Employee Says Onvoy, MCI Illegally Diverted Calls," *The Wall Street Journal*, Thursday July 31, 2003, p B1.

⁵ Janet St. James, *Family Sues over Transplant Death*, WFAA-TV, March 13, 2003.

⁶ Mary G. Lankford et al., "Influence of Role Models and Hospital Design on Hand Hygiene of Health Care Workers," *Emerging Infectious Diseases*, Vol. 9, No. 2, February 2003.

⁷ Confidential interviews conducted in two hospitals in 1990 and 2002.

⁸ "Colds Uncommonly Costly," *Today*, February 25, 2003. p 9D. (From research reported in *Archives of Internal Medicine*, February 24, 2003.)

⁹ From an AP press release on CNN.com

¹⁰ Ibid.

¹¹ Confidential culture assessments performed in 1995-96 in Florida.

¹² By David Ulrich, Louis Carter, Jim Bolt, and Marshall Goldsmith, eds., *Best Practices in Organization Development, Leadership, & Change: Organizational Champions of Leadership, Innovation, and Organizational Transformation*.