THE ROLE OF PSYCHOLOGICAL SAFETY

MAXIMIZING EMPLOYEE INPUT AND COMMITMENT

Amy Edmondson

When Julie Morath came on board as chief operating officer at Children's Hospital and Clinics in Minneapolis, Minnesota, her goal was simple: 100 percent patient safety for the hospitalized children under her care. To do that, however, she believed she would first have to make it easier for hospital staff to talk about mistakes. This was late 1999, and patient safety was still a new topic in the healthcare community. It's not that clinicians were unaware of the risks to patients; it's just that they tended to think that when things went wrong, someone was to blame. And that made it hard for them to speak up. In short, to improve patient safety, she needed a climate of *psychological safety*. Only then could the hospital find new ways to enhance the safety of their vulnerable young patients.

As in many workplaces today, in a tertiary care hospital, the work is complex. It's challenging to get every single task done perfectly every single time. To begin with, every patient is different. No two care episodes are identical. Upping the ante, highly interdependent care work must be seamlessly coordinated among narrow specialists with complementary knowledge and skills. Multiple, interdependent departments—pharmacy, laboratory, physicians, and nursing—who have conflicting priorities about what service to provide at what time—must coordinate actions for safe care to be consistently delivered. And so, a certain number of mishaps are sometimes seen as just "the way things are."

Morath felt that this attitude had to change if progress was to be made. In retrospect, what happened to profoundly shift the climate for speaking up at Children's can be divided into three categories: *setting the stage, inviting participation,* and *responding productively.*

Setting the Stage

As soon as she took the job, Morath began speaking to large and small groups in the hospital to explain that healthcare delivery, by its nature, was a complex system prone to breakdowns. She introduced new terminology ("words to work by") that altered the meaning of events and actions in important ways; for instance, instead of an "investigation" into an adverse event, the hospital would use the term "study"; instead of "error," she suggested people use "accident" or "failure." In subtle but important ways, Morath was trying to help people *think* differently about the work—especially about what it means when things go wrong. These leadership actions comprise what I refer to as *framing* the work.

Frames consist of assumptions or beliefs that we layer onto reality. All of us frame objects and situations automatically. Our focus is on the situation itself, and we are typically blind to the effects of our frames. This is because our prior experiences affect how we think and feel about what's presently around us in subtle ways. We believe we're seeing reality—seeing what is *there*. For instance, if we frame medical accidents as indications that someone screwed up, we will ignore or suppress them for fear of being blamed or of pointing the finger at a colleague. Fortunately, automatic frames can be shifted to create a shared frame that more accurately represents reality. When Morath gave presentations that called attention to hospital care as a complex, error-prone system what she was doing, she was framing the work—or, more accurately, *re*framing it. Her goal was to help people shift from a belief that incompetence, rather than system complexity, was to blame for safety lapses. This shift would prove essential to helping people feel safe speaking up about the problems, mistakes, and risks they saw.

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In setting the stage for open discussion of error, Morath also communicated urgency about the goal of 100 percent patient safety. I consider this an important stage-setting act as well, because it helped people reconnect with the reasons they went into healthcare in the first place—to save lives.

Inviting Participation

As you may imagine, hardworking neonatal nurses and experienced pediatric surgeons did not immediately flock to Morath's office to confess to having made or seen mistakes, but she resisted the temptation to lecture. Instead, she did something as simple as it was powerful. She asked a question: "Was everything as safe as you would like it to have been this week with your patients?" The question—open, curious, direct—was respectful and concrete: "this week," "your patients." Its very wording conveys genuine interest. Interestingly, she did *not* ask, "Did you see lots of mistakes or harm?" Rather, she invited people to think in aspirational terms. Sure enough, people began to feel safe enough to bring up incidents they had seen or contributed to.

Morath also invited participation with structural interventions. For instance, she set up a cross-functional, multilevel team called the Patient Safety Steering Committee to lead the change initiative. Each

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team member was invited with a personal explanation for why his or her perspective was sought. Further, Morath introduced a new "blameless reporting" policy to invite confidential reports about risks and failures people observed. Then, as people began to feel safe enough to speak up, Morath led as many as 18 focus groups to make it easy for people throughout the organization to share concerns and experiences.

These simple structures made speaking up easier. When you join a focus group, your input is explicitly requested. It feels more awkward to remain silent than to offer your thoughts.

Responding Productively

Having encouraged people to speak up, the true test is then how leaders respond when people actually do so. A productive response must not be angry or disdainful but instead appreciative and respectful, offering a path forward.

Consider the "focused event analysis," a cross-disciplinary meeting that Morath instituted at Children's to bring people together after a failure and to identify contributing factors with the goal of improving the system to prevent future similar failures. Equally important, the blameless reporting policy enabled productive responses to messengers who bring bad news about an error or mishap

Morath's story shows how a leader set out to create psychological safety as a means to improve an organization's performance. The goal of this article, adapted from my recent book *The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth,* is to offer specific ways leaders can build psychological safety in any organization by setting the stage, inviting participation, and responding productively. Table 1 summarizes my framework. To develop these behavioral tools, I drew from both research and my years of experience studying and consulting with organizations around the world.

How to Set the Stage for Psychological Safety

Whenever you are trying to get people on the same page, with common goals and a shared appreciation for what they're up against, you're setting the stage for psychological safety. The most important skill to master is that of framing the work. First, I'll explain core elements of framing the work—*reframing failure* and *clarifying the need for voice*. From there, I'll move on to another stage-setting tool in the leader's toolbox: *motivating effort*.

Framing the Work

Reframing Failure

Because fear of (reporting) failure is such a key indicator of an environment with low levels of psychological safety, how leaders present the role of failure matters.

Category	Setting the stage	Inviting participation	Responding productively
Leadership tasks	Frame the work • Set expectations about failure, uncertainty, and interdependence to clarify the need for voice Emphasize purpose • What's at stake; Why it matters for whom	Situational humility • Acknowledge gaps Practice inquiry • Good questions • Intense listening Set up structures and processes • Forums for input • Guidelines for discussion	Express appreciation • Listen • Acknowledge and thank Destigmatize failure • Look forward • Offer help • Discuss, consider, brainstorm next steps Sanction Clear Violations
Accomplishes	Shared expectations and meaning	Confidence that voice is welcome	Orientation toward continuous learning

TABLE 1. THE LEADER'S TOOLBOX FOR BUILDING PSYCHOLOGICAL SAFETY

Failure is a source of valuable data, but leaders must understand and communicate that learning only happens when there's enough psychological safety to dig into failure's lessons.

At one end of the spectrum is high-volume repetitive work, such as in an assembly plant, a fast-food restaurant, or even a kidney dialysis center. Failing to correctly plug a patient into a dialysis machine or install an automobile air bag in precisely the right manner can have disastrous consequences. In this kind of work, it's vital that people eagerly catch and correct deviations from best practice. Here celebrating failure is a matter of viewing such deviations as "good catch" events and appreciating those who noticed tiny mistakes as observant contributors to the mission.

At the other end of the spectrum lies innovation and research, where little is known about how to obtain a desired result. Creating a movie, a line of original clothing, or a technology that can convert seawater to fuel are all examples. In this context, multiple failures must be courted and celebrated because they are the only means to success. In the middle of the spectrum, where much of the work done today falls, are complex operations, such as hospitals or financial institutions. Here, vigilance and teamwork are both vital to preventing avoidable failures and celebrating intelligent ones.

Reframing failure starts with understanding a basic typology of failure types: *preventable failures* (never good news), *complex failures* (still not good news), and *intelligent failures* (not fun—but must be considered good news because of the value they bring). Preventable failures are deviations from recommended procedures that produce bad outcomes. If someone fails to don safety glasses in a factory and suffers an eye injury, this is a preventable failure. Complex failures occur in familiar contexts when a confluence of factors come together in a way that may never have occurred before.

Intelligent failures, like the preventable and complex, are still results no one wanted. But, unlike the other two categories, they constitute a thoughtful foray into new territory and must be celebrated so as to encourage more of them. Table 2 presents definitions and contexts to clarify these distinctions. An important part of framing is making sure people understand that some failures are genuinely good news; some are not, but no matter what type they are, our primary goal is to learn from them.

Clarifying the Need for Voice

Framing the work involves calling attention to other ways, beyond failure's prevalence, in which tasks and environments differ. Three especially important dimensions are *uncertainty, interdependence,* and

	Preventable	Complex	Intelligent
Definition	Deviations from known processes that produce unwanted outcomes	Unique and novel combinations of events and actions that give rise to unwanted outcomes	Novel forays into new territory that lead to unwanted outcomes
Common causes	Behavior, skill, and attention deficiencies	Complexity, variability, and novel factors imposed on familiar situations	Uncertainty, experimentation, and risk taking
Descriptive term	Process deviation	System breakdown	Unsuccessful trial
Contexts where each is most salient	Production line, manufacturing Fast-food services Basic utilities and services	Hospital care NASA Shuttle program Aircraft carrier Nuclear power plant	Drug development New product design

[1]This table presents a modified version of a table that appeared in Chapter 5, pp. 166, of Edmondson, A.C. *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy.* San Francisco, CA: Jossey-Bass, 2012.

TABLE 2. FAILURE ARCHETYPES: DEFINITIONS AND IMPLICATIONS

what's at stake—all of which also have implications for failure. Emphasizing uncertainty reminds people that they need to be curious and alert to pick up early indicators of change in, say, customer preferences in a new market, a patient's reaction to a drug, or new technologies on the horizon.

Interdependence encourages frequent conversations to figure out the impact their work is having on others and to convey in turn the impact others' work has on them. Leaders should frame the work by emphasizing the need to take the interpersonal risks of sharing ideas and concerns.

Clarifying the stakes is important whether the stakes are high or low. People are more likely to speak up—thereby overcoming the inherent asymmetry of voice and silence—if leaders frame its importance. Similarly, reminding people that the only thing that is at stake is a bruised ego when a lab experiment doesn't go as hoped is a good way to get them to be willing to go for it—offer possibly crazy ideas and figure out which ones to test first!

Finally, how people typically see the boss presents a crucial area for reframing. By default, bosses are tacitly viewed as having answers, able to give orders, and assess whether the orders are well executed. With this frame, others are merely subordinates expected to do as they are told. Notice that this default frame makes interpersonal fear sensible. In a world in which bosses have the answers and authority over how your work is judged, it makes sense to fear the boss and to think carefully about what you reveal.

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In contrast, the reframe shows that leaders must establish and cultivate psychological safety to succeed in most environments today. The leader is obliged to set direction, to invite crucial, relevant input to clarify and improve on that direction, and to create conditions for continued learning to achieve excellence.

In the reframe, those who are not the boss are seen as valued contributors—that is, as people with crucial knowledge and insight. Leaders who understand that work is uncertain, interdependent, and requires continuous learning to figure out when and how to change course, must consciously reframe how they think, from the default frames that we all bring to work unconsciously.

Motivating Effort

Emphasizing a sense of purpose is another key element of setting the stage for psychological safety. Leaders who remind people of why what they do matters—for customers, for the world—help create the energy that carries them through challenging moments. This also helps them overcome the interpersonal risks they face at work.

How to Invite Participation So People Respond

The second essential activity in the leader's toolbox is actively inviting engagement—because otherwise most people will just "play it safe." Two essential behaviors that signal an invitation is genuine are *adopting a mind-set of situational humility* and *proactive inquiry*. *Designing Structures for Input*, another powerful tool I discuss here, also invites voice.

Situational Humility

The bottom line is that no one wants to take the interpersonal risk of imposing their ideas when the boss appears to think he knows everything. A learning mind-set, which blends humility and curiosity, mitigates this risk. Research shows that when leaders express humility, teams engage in more learning behavior.

In our study of neonatal intensive care units mentioned in Chapter 2 of *The Fearless Organization*, Ingrid Nembhard, Anita Tucker, and I found that NICUs with high psychological safety had substantially better results from their quality improvement work than those with low psychological safety. A factor we called *leadership inclusiveness* made the difference. To illustrate, inclusive medical directors (physicians in charge of the intensive care organization) said things like, "I may miss something; I need to hear from you." Others perhaps took it for granted that people knew to speak up. Our survey measure rated three behavioral attributes of leadership inclusiveness: (1) leaders were approachable and accessible; (2) leaders acknowledged their fallibility; and (3) leaders proactively invited input from other staff, physicians, and nurses. The concept of leadership inclusiveness thus captures situational humility coupled with proactive inquiry (see below).

Proactive Inquiry

The second tool for inviting participation is inquiry—purposeful probing to learn more about an issue, situation, or person. The foundational skill lies in cultivating genuine interest in others' responses. Why is this hard? Because all adults, especially high-achieving ones, are subject to a cognitive bias called *naive realism* that give us the experience of "knowing" what's going on. As noted above, we believe we see "reality"—rather than our subjective view of reality. As a result, we often fail to wonder what others are seeing. Worse, many leaders, even when they are motivated to ask a question, worry that it will make them look uninformed or weak. Further exacerbating the challenge, some companies sport "a culture of telling," as a senior executive in a global pharmaceutical company put it in a recent interview with the author. In a culture of telling, *asking* gets short shrift.

Yet when leaders overcome these biases to ask genuine questions, it fosters psychological safety and tends to make the leader seem, not weak, but thoughtful and wise.

The essential skill of inquiry involves picking the right type of question for a situation. For instance, questions

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can go broad or deep. To broaden understanding of a situation or expand an option set, ask, "*What might we be missing?" "What other ideas could we generate?" or "Who has a different perspective?*" Such questions ensure that more comprehensive information is considered and that a larger set of options is generated related to a problem or decision. Other questions are designed to deepen understanding. Ask: "*What leads you to think so?"* or "*Can you give me an example?"* Such questions are crucial to helping people learn about each other's expertise and goals and indicates to others that their voice is desired. This makes that moment psychologically safe for offering a response.

Designing Structures for Input

A third way to invite participation and reinforce psychological safety is to implement structures designed to elicit employee input.

How to Respond Productively to Voice: No Matter Its Quality

To reinforce a climate of psychological safety, it's imperative that leaders—at all levels—respond productively to the risks people take. Productive responses are characterized by three elements—*expressions of appreciation, destigmatizing failure,* and *sanctioning clear violations.*

Express Appreciation and Destigmatizing Failure

Appreciative responses may range from the small (*thank you so much for speaking up*) to the elaborate—celebrations or bonuses in response to intelligent failure. Failure is a necessary part of uncertainty and innovation, but this must be made explicit to reinforce the invitation for voice.

I frequently ask managers, scientists, salespeople, and technologists around the world the following question: What percent of the failures in your organizations should be considered blameworthy? Their answers are usually in single digits—perhaps 1–4 percent. I then ask: What percent are *treated* as blameworthy? Now, they say (after a pause or a laugh) 70–90%! The unfortunate consequence of this gap between simple logic and behavioral response is that many failures go unreported, and their lessons are lost.

Sanction Clear Violations

Most people are thoughtful enough to recognize that when someone violates rules or repeatedly takes risky shortcuts, they are putting themselves, their colleagues, and their organization at risk. In short, psychological safety is reinforced rather than harmed by fair, thoughtful responses to potentially dangerous, harmful, or sloppy behavior, which includes firing.

Conclusion

The practices described in this article call for self-awareness and interpersonal skill. They take effort and repeated practice to master. Perhaps the most important aspect to having an impact on employee commitment and voice is the consistent exercise of these practices over time. It is not a matter of trying them out once and checking the box. Good leaders consistently help people to understand, appreciate, and embrace the shared challenge that lies ahead. This is how psychological safety is built and reinforced in ways that maximize employee input and commitment.

Adapted from the book *The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth*, by Amy Edmondson (Wiley, 2018).

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