GREAT LEADERS DO NOT SOLVE PROBLEMS

Moving From Good to Great Safety Leadership

By Earl Blair

AS LEADERSHIP EXPERT Jim Collins (2001) affirms in the book *Good to Great*, "Good is the enemy of the great." The time devoted to good efforts can prohibit individuals and organizations from doing great things that bring forth superior results.

The sincere efforts organizations make reacting to injuries and adverse events are good. On the other hand, the effective efforts that lead to preventing these injuries in the first place are great.

KEY TAKEAWAYS

- **Good leaders solve problems, but great leaders prevent problems from happening.**
- **This article provides clues to address two basic concerns: why risks remain hidden in organizations, and how to uncover hidden risks.**
- **The safety profession is about prevention. Safety professionals add value to their organizations by proactively identifying existing threats and opportunities to prevent injuries and fatalities.**

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Becoming great in safety management involves designing systems that effectively identify and address risks. Identifying risks can be especially challenging because serious risks and safety-related problems often remain hidden within an organization.

Great leaders find problems before they result in disasters. Timing is the critical factor in proactive approaches. Great leaders observe, inquire, and reflect on lessons learned and recognize patterns in their organizations. These skills and a mindset of intellectual curiosity are essential for optimal safety performance. These skills can be learned by leaders and safety professionals.

How can organizations identify issues or hazards before they develop into major problems? This article explores two important questions: 1. why do risks sometimes remain hidden in organizations?; and 2. how do we uncover the hidden risks in organizations?

Question 1: Why Do Risks Remain Hidden in Organizations?

Roberto (2009) notes that every organization, no matter how successful, has plenty of problems. These problems often lie beneath the surface, hidden from view. Great leaders recognize that there is no such thing as "no problems" just as there is no such thing as "zero risk." If leadership allows problems to remain hidden, they can mushroom and become unmanageable, resulting in unwanted events. As baseball player Yogi Berra reportedly once said, "Problems are not like fine wine; they do not improve with age."

Risks Remain Hidden in Cultures That Discourage Transparency & Reporting

Culture can be defined as "a set of common practices in an organization." These practices are influenced by the core values of an organization. According to Manuele (2020), "Safety is culture driven. Everything that occurs or doesn't occur that relates to safety is a reflection of an organization's culture" (p. 49).

Many kinds of cultures contribute to keeping risks hidden. Following are examples of cultures or subcultures that contribute to hidden risks.

Cultures Characterized by Blame & Fear

What impact does a culture of blame have on activities to identify hazards? When people are

punished for bringing bad news to management's attention, hazards and incidents remain hidden. Looking for someone to blame after a negative incident is relatively common in organizations and society in general. Cultures characterized by blame and fear ultimately inhibit reporting. Manuele (2020) emphasizes removing the barriers to reporting: "For incidents to be investigated, they must be reported. Organizations should have all barriers to reporting removed" (p. 39). Management is responsible for creating a culture of learning, openness and transparency. No one should be punished for sharing bad news.

Which of these is of greater value to an organization: transparent reporting of hazards or discipline for violations of a safety rule? In the author's opinion, reporting near-hit incidents that could have a serious impact is of greater value to an organization than disciplining an employee for reporting a near-hit when there was a safety violation in the chain of events prior to the incident.

For example, if employees perceive that a coworker was punished unfairly to set an example, they will likely not report incidents in the future. Greater value is usually derived from determining why an employee took a certain action rather than punishing the employee for a violation that contributed to an injury.

Cultures Immersed in Groupthink & Happy Talk

Groupthink can be defined as the lack of individual creativity or a (lack of) sense of personal responsibility, that is sometimes characteristic of group interaction. Leaders who want to find problems before they happen must have the courage to stand against the group sometimes and ask tough questions that might reveal answers that are inconsistent with company traditions.

Harvard professor and leadership expert John Kotter explains that "happy talk" is a source of complacency. Kotter (1996) notes that people within an organization who are relatively unaffected by complacency may be:

> . . . lulled into a false sense of security by senior management's "happy talk." "Sure, we have challenges, but look at all that we've accomplished." People who were around in the 1960s will remember a terrifying example of this: the many reports of how the United States was winning the war in Vietnam. Although happy talk is sometimes insincere, it is often the product of an arrogant culture that, in turn, is the result of past success. . . . For individuals, it creates an ego problem; for firms, a cultural problem. (p. 41)

Some chilling case studies illustrate arrogant cultures that failed to identify and eliminate their major risks. Loud's (2016) article on major risks details three case studies of organizations that, from all appearances, were doing a great job in safety. These organizations shared similar success stories including significantly lower incidence rates than most companies in their industry. All three organizations received positive recognition and awards for their safety performance. This can lull people into groupthink and happy talk about the impressive safety incidence rates and resulting awards. The final commonality between these three organizations was that "All failed to deal adequately with long-standing risk factors, resulting in catastrophic losses of human life, financial resources and organizational credibility" (Loud, 2016, p. 51).

Cultures That Sloganize Zero Injuries While Practicing Zero Tolerance

Case study: A major chemical company expected everyone to buy into the slogan "All injuries are preventable." One of its east coast sites did not record workplace injuries, as they were perceived to be avoidable and unacceptable (zero tolerance). Since injuries were not counted and properly recorded on the OSHA log, it outwardly appeared the site was experiencing zero injuries. During an inspection, OSHA discovered the injuries on the records in the company's first-aid station. OSHA imposed a large fine on the company for this failure.

The better approach to zero is to aim for zero exposures to unnecessary hazards. Eliminating hazards and exposures is the focus of more proactive organizations.

Cultures That Suffer From Risk Blindness

Risk blindness means the population is unaware that the risk exists. A culture that is risk blind is unaware to the fact that it is risk blind.

Problems will always exist. The real problem is having problems that remain hidden. Pushing the zero-injuries philosophy can contribute to a lack of awareness.

Risk blindness may be caused by a lack of a sense of urgency for finding and addressing hazards. Even companies in high-hazard industries may have an established sense of urgency for production deadlines or quality of services yet lack a sense of urgency for controlling and eliminating hazardous exposures.

By default, a risk-blind organization is reactive to risk discovery. Rather than proactively developing and following a strategy to conduct risk assessments, this organization is likely to be busy responding to many fires. It conducts investigations for incidents that could have been avoided in the first place by proactively addressing risks.

Case study: A 1999 Glenbrook NSW Rails incident in Australia resulted in the death of seven people and injuries to many others. Professor of sociology and process safety expert Andrew Hopkins (2005) examined the various dominant cultures that existed and contributed to the rail collision. The predominant cultures in the Glenbrook case study included:

- A culture of rules: There were eight large volumes of complex safety rules.
- A culture of silos: The rails organization was fragmented.
- A culture of on-time running: This was essentially a positive culture but the extreme focus on on-time running contributed to a lack of safety awareness.
- A risk-blind culture: There was a reliance on rules and silos.

Hopkins noted that there was also a culture of blame and fear. There were instances of employees being terminated for reporting hazards. These factors disempowered employees and engendered a sense of fatalism and the deadly risk-blind culture (Hopkins, 2005).

Risks Remain Hidden When Latent Conditions Are Not Addressed

Reason (1997) distinguishes between active failures and latent failures in the Swiss cheese model of defense. Active failures are risky behaviors that are typically committed immediately preceding an incident. Examples of latent failures include inadequate staffing, error provocative conditions and lack of preventive maintenance. Latent conditions are usually a result of things that are not done or failures of omission. Latent conditions may exist for years without an organization taking notice and may be related to risk-blindness or to a risk-denying culture.

Case study—Latent conditions: Andrew Hopkins's expertise has been tapped for major incident investigations on three continents. Hopkins (2008) conducted a detailed analysis about the 2005 BP Texas City explosion that resulted in 15 fatalities and more than 100 injuries. Examples of latent conditions from this unfortunate event include:

•Failure to perform preventive maintenance. There were incidences of safety work orders closed out even though the work was not done (e.g., crucial site glass that was inadequate and did not allow visibility, safety valves that were known to be inoperative).

•Operators were inadequately educated and trained for emergency situations.

•Outdated equipment being used (e.g., blowdown drums that should have been replaced with flares, which could have prevented the explosion).

•Lack of understanding of organizational and process complexity. In the BP case the complexity involved an organizational merger and the Process Safety Management standard that is complex and normally best understood by engineers. When OSHA visited the site prior to the explosion to follow up on fatalities, its findings were related to personal safety rather than the many process safety issues that existed at the site.

•Fragmented communication was allowed to exist in a high-hazard process. Communications can become fragmented with too much information or too much white noise. In the BP case, the immediate issue was too little communication (e.g., failure to communicate with clarity between the shifts during the start-up and shift change; Hopkins, 2008).

Risks Remain Hidden When Leadership Falls Into Isolation Traps

Any leader who is serious about the task of becoming a problem finder cannot allow themselves to be isolated. The isolation trap occurs when leaders are isolated from the employees who actually know about the problems that threaten the organization (Roberto, 2009).

As noted, one cannot solve a problem one does not know about. This is why it is important for leaders to be problem finders who embrace problems as opportunities. They must recognize the issues early before they mushroom and result in serious injuries or tragedies.

Question 2: How Do We Uncover Hidden Risks in an Organization?

Leaders can add value and make a greater positive impact on their organizations by deliberately becoming problem finders and learning to embrace problems as opportunities.

Uncover Risks by Embracing Problems as Opportunities

Organizations can develop cultures that embrace problems as opportunities. Individuals can develop a mindset of embracing problems as opportunities to learn and improve.

Case study—Embracing problems as opportunities: The benchmark example for embracing problems is the Toyota Production System. Toyota embraces problems and calls them opportunities. But it is more than semantics; the company has a system and culture that deals with issues by seeking out permanent solutions. The solutions are standardized so that the problems do not happen again organization wide.

Organizations can customize and institute systems like the Toyota Production System and integrate them into their existing culture. For Toyota, it goes something like this:

1. Opportunity: An opportunity is identified by a team member or during a Gemba walk. Gemba is a Japanese term that can be translated as "the place where the work is done" or "the place where value is created."
2. Countermeasure: The team, comprised of four members and a leader, goes to work developing a countermeasure (or intervention) that will solve the issue.
3. True countermeasures: If the problem is solved for good, it is considered a true countermeasure. A true countermeasure is equivalent to a permanent fix through a higher-level hierarchy of controls intervention: elimination, substitution or engineering long-term solutions.
4. Standardization: Once a true countermeasure is identified, it is standardized across the organization (Blair, 2017).

Uncover Risks by Developing Leaders' Skills as Problem Finders

Great leaders exhibit foresight and the ability to think steps ahead and identify patterns. Leadership experts Kouzes and Posner (2010) note that "focusing on the future sets leaders apart."

Case study—Prescient leadership: Roberto (2009) includes a case study on Winston Churchill titled "A Most Prescient Leader." A prescient person is one who demonstrates foresight and anticipates the course of future events. Roberto notes that during his remarkable career, Churchill seemed to see threats from German militarism, Hitler and Soviet expansionism long before others did. How did Churchill predict German militarism and Soviet expansionism so precisely?

•He immersed himself in the job he held by traveling and being in the thick of action.

•He spoke relentlessly with people far and wide from inside and outside the government.

•He demonstrated a remarkable level of inquisitiveness and curiosity.

•He loved speaking with the people on the front lines (Roberto, 2009).

As a problem finder, Churchill was a leader who resisted both groupthink and becoming isolated from the action and people. His extraordinary foresight was perhaps the main factor that made Churchill a great leader.

What could possibly be more valuable to organizations than leaders and safety professionals who develop

and practice the skills that build high levels of prescience and foresight?

Uncover Risks & Develop Problem-Finding Skills by Asking Great Questions

In the book *Good Leaders Ask Great Questions*, leadership expert John Maxwell (2014) specifies why leaders should ask questions. A few benefits of asking great questions are:

- "You only get answers to the questions you ask".
- "Questions unlock and open doors that otherwise remain closed."
- "Questions are the most effective means of connecting with people" (Maxwell, 2014).

PURPOSEFUL MINDSET OF GEMBA WALKS TO ASSESS RISK

Meaningful observation for the purpose of prevention can occur during Gemba walks. These walks can also serve as a vehicle for asking great questions of employees in a caring, relaxed manner while on their turf.

Purpose
Focused Observation: Be a Problem Finder
- **Safety sleuth: Become a detective for risk identification.**
- **Timing: Identify hidden hazards before they become undesirable events.**
- **Teamwork: Encourage employees to be problem finders also.**

Mindset
Identify & Embrace Problems
- **Ongoing curiosity: Embrace problems as opportunities to learn and improve.**
- **Enlightenment: Better understand the work as done versus standard procedures.**
- **Servant leadership: How can I better serve the safety needs of employees?**

Methods
Practice & Develop Value-Added Skills
- **Observe: People, the process, the successes, the potential issues.**
- **Inquire: Ask great questions to identify problems that need addressing.**
- **Actively listen: Listen for understanding, novelties and opportunities.**

Follow Up
Handle Problems Before They Mushroom
- **Intervene: Select appropriate interventions.**
- **Correct: Take corrective actions.**
- **Communicate: Publish the status of actions taken or in queue.**

Measure
Integrate Gemba Safety Walks Into the Management System
- **Key performance indicator: Implement a KPI for Gemba safety walks.**
- **Standardize: Standardize solutions as appropriate.**
- **Discipline: Gemba walks are relatively simple but not necessarily easy to do.**

Benefits
Effective Gemba Walks Can Result in Enormous Payback
- **Commitment: Demonstrates visible ongoing support for reducing hazards.**
- **Increased trust: Respect for employees is practiced.**
- **Improved accessibility: From supervisors and managers to employees.**

Part of the methodology to becoming a problem finder involves asking the right questions. The kinds of questions might be a little out of the ordinary such as what-if questions. Questions can provide answers with insights that allow us to build better solutions. Problem-finder questions, posed both to oneself and others, might include:

- Why might this situation become a serious problem?
- How can we prevent this problem from happening?
- What if our safety defenses failed in this context?
- Where do you think the next serious incident will occur at this site? Why?

Another source for value-added questions includes lessons learned or that should have been learned from near-hits and injuries or incidents from other sites and similar industries. What could the organization be doing right now to prevent the near-hit from being a future hit or a tragic incident similar to one that may have occurred at another location?

Uncover Risks by Overcoming Isolation Traps

It is important for leaders to prevent problems from being hidden and unaddressed. Issues can only be accurately perceived as opportunities when they are properly identified, thoroughly analyzed and improved. Isolation traps occur when leadership remains buried in their offices or workstations under a stack of projects and paperwork, reviewing pie charts on their monitors. The missing element is firsthand observation of what is actually going on where the work is taking place. This isolation contributes to a culture of risk blindness. It is nearly impossible to have great foresight in this context.

From the Churchill case study, Churchill did not simply listen to the people in the government or in his own group, rather he purposely overcame isolation to better understand precisely what was going on and to become the most prescient leader of the 20th century.

Practice Gemba Walks to Assess Risks & Develop Leadership Skills

Roberto (2009) recommends that leaders practice firsthand observation to increase their effectiveness:

> Effective leaders . . . break out of the isolation of the executive suite and "get out and look." They do not simply "manage by walking around." They become careful and systematic observers of people, processes and facilities. They immerse themselves in the everyday contexts in which the work is being done. (p. 62)

This is part of the impact behind assessing risks with Gemba walks: Leaders can spot the problems "where the work is being done" in their early stages. Additional value is possible from simultaneously building relationships and reinforcing the positive things employees are doing to identify and control risks. Leaders may not be aware of what is actually going on in the workplace if their time is spent at the boardroom table and in their offices, that is, what Roberto calls the "isolation trap."

Meaningful observation for the purpose of prevention can occur during Gemba walks. In addition, Gemba walks can serve as a vehicle for asking great questions of employees in a caring and relaxed manner while on

their turf (see "Purposeful Mindset of Gemba Walks to Assess Risk" sidebar).

Toyota recognized the importance for leadership to observe the place where the work is done and established Gemba walks. Organizations can tailor their walks for the purpose of helping leaders be problem finders focused on identifying risks.

Leadership boils down to influence. Gemba walks are a potentially powerful influence on employees and the culture of an organization. Employees witness that leadership is committed and acting on behalf of their safety. This visible commitment is powerful and especially evident when the walks are dedicated to identifying, reducing and eliminating hazards.

Gemba walks or something similarly tailored can be adapted, designed and practiced in a manner that fits and enhances the existing culture of an organization. The primary purpose of these walks is to find hazards and risks before they become undesirable events.

In addition to observing and asking questions during these walks, it is important that organizational leaders practice active listening. The importance of listening should not be overlooked as a valuable leadership skill. Leaders can encourage and value input from workers, listening attentively to their concerns and suggestions during these walks.

The purpose of these leadership walks is not primarily as an audit or inspection; systems are usually already in place for inspections and audits. Leadership walks should be separate from inspections because measures used to inspect people are perceived negatively. Employees are less likely to voluntarily report issues if they perceive the leadership walks are simply management inspections.

Organizations can benefit by developing a metric to standardize and implement these Gemba walks. Consider developing a formal metric as a primary measure of leadership support. In doing so, observe the following:

- Seek agreement and input of stakeholders, leadership and employees to the metric.
- The primary purpose for the walks is to identify risks and related opportunities.
- Ensure that a mechanism is in place to follow up and close the loop on issues discovered.
- The vision and long-term strategy for the walks involves eliminating risks and developing the safety culture.

Conclusion

Great leaders observe, inquire, recognize patterns and reflect on lessons learned in their organizations. These skills and a problem-finder mindset are paramount for identifying and eliminating risks. Importantly, these skills and mindset can be learned and practiced by leaders. Leaders and safety professionals can add value to their organizations by practicing these proactive methods.

Roberto (2009) explains that the overarching mindset of great leaders and successful safety professionals is the same. He concludes:

> Successful leaders demonstrate intellectual curiosity, adopt systemic thinking and exhibit a healthy dose of paranoia. They do not wait for problems to come to them. They behave much more proactively. They seek out problems. They embrace them. . . . Successful leaders do not see problems as threats. They see every problem as an opportunity to learn and improve. (p. 193)

The journey to great leadership is never-ending. Adding value to an organization by being a problem finder involves more than simply developing these specific skills; the leader must possess a mindset of being a searcher and a hunter, a sleuth-like person who focuses on preempting threats of future injuries and tragedies.

As Peter Drucker has been quoted as saying, "Results are obtained by exploiting opportunities, not by solving problems." This concept of preventing problems before they happen is at the heart of how safety professionals add value and contribute to their organizations. The strategies and practices recommended here can enhance OSH professionals' prevention efforts and reduce the frustration of constantly reacting and responding to undesirable incidents. **PSJ**

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Earl Blair, Ed.D., CSP, is a visiting lecturer of safety management at Indiana University. He also provides safety consulting and training services and frequently presents at corporate, national and international events. Blair previously worked as a safety professional helping various Fortune 500 companies improve safety performance. He has received many awards as a professor and author, including the Lifetime Achievement in Safety Award from BLR and the honor of ASSP Fellow in 2019. Blair is a professional member of ASSP's Central Indiana Chapter and a member of the Society's Consultants Practice Specialty.