FRAUD TALK – EPISODE 114

Why Psychological Safety is Pivotal for Ethical Company Cultures – Garth Sheriff

During the 2021 ACFE Fraud Conference Canada, the founder of Sheriff Consulting, Garth Sheriff, CPA, discussed the importance of psychological safety for ethical decision making – and how the lack of it in an organization can lead to disaster.

Transcript

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Sarah Thompson: Hello and welcome to *Fraud Talk,* the ACFE's monthly podcast.

Garth Sheriff: The question is, what is psychological safety? The reason I really enjoy this term and I like exploring this is that psychological safety is a research-based organizational psychology/behavior-based term that comes from some prominent researchers. It was first brought into my perception and my understanding with an article from *The New York Times*, what Google learned from its quest to build a perfect team.

Google worked in a lot of teams. What they wanted to figure out was that when teams change projects or change personnel, their performance changes. Some teams that were high-performing, you just change one aspect of the team dynamic. All of a sudden, the team goes to low-performing. They wanted to use a lot of existing research to figure out what is the magic ingredient that regardless of who the team members are, the project will keep teams performing at a high level.

They did not find that magic ingredient. Otherwise, I would tell you, but what they did find was correlation. One of the items they found a correlation and a big one was psychological safety. This brought the work of Dr. Amy Edmondson, whose work is the key work for psychological safety, into prominence because that article was a very popular article. It went around to many different spaces.

The term "psychological safety" became this buzzword, this interesting concept, especially for those that are analytical thinkers because it's supported by research. I'm showing a hospital floor here because Dr. Amy Edmondson's work really started off in a hospital. That's where her research base was. In terms of looking at the dynamics between teams, she had an inventory of what she think would be attributes of high-performing teams and attributes of low-performing teams.

This was through her research and she wanted to go and experiment to see if these attributes held true. She thought the best place to look at this is a place where there's clear hierarchical divisions, doctors and nurses. She went into ER rooms across different hospitals in the United States and looked at the relationships between doctors and nurses. What she wanted to see as any researcher was that her hypothesis was true, that doctors and nurses that were high-performing would have more of the attributes on her list ticked off.

She needed a way of delineating or separating high-performing nurse and doctor teams to low-performing. What she did was looked at error rates. Errors are reported in hospitals. Nurse and doctor

teams reported to administration in terms of potential missed medical diagnosis, wrong medical dosages. Different situations can happen inside a hospital or ER room that might result in an error.

She got the information from each hospital and she decided to use that as the barometer. Nurses and doctors with really low error rates, they weren't making a lot of mistakes that was on high-performing teams. She would expect to see those nurses and doctors that had low error rates. They weren't making mistakes. They weren't misdiagnosing patients or wrong medicine to expect them to have more attributes of higher-performing teams.

Then the teams that were having higher error rates, situations that they were reporting errors that were happening to the administration, she said, "Well, this would make sense that they were lower-performing teams," would have less items on her inventory. My wife is a professor. As a professor who does research, you do want your hypothesis to work out. Not that you have a bias, but if your hypothesis does not work out, you have a lot more work ahead of you.

Well, what happened with Dr. Amy Edmondson, a professor Novartis at Harvard, is that her hypothesis, her paper didn't work out. In fact, it was the opposite, which was baffling to her at the time. The teams that were reporting the higher error rates had many more indicators of being higher-performing teams, whereas the teams that had lower error rates did not show up in terms of attributes that she would look for in high-performing teams, so she was flummoxed here.

What was happening was, literally, the opposite results. She went back to the drawing board and went back with a one-year intensive work, brought in a research assistant. She documented this in her book called, *The Fearless Organization*. She went back and tried to figure out what happened. This is where psychological safety really grew to prominence in her research. This was the key here.

What she found after digging into the data that the teams that were reporting higher error rates were actually reporting those rates, that they were being honest reporting. The nurses and doctor teams were going to the administration and saying, "We made a mistake. We want you to know." Whereas the teams with the lower reporting rates, what she discovered is that they were under-reporting the errors and, specifically, the nurses were and what was happening. She went and dug into this.

Well, nurses and doctors have a classically hierarchical relationship. Doctors are individuals who make the decisions. Nurses generally follow the guidance of the doctors. Now, should that be the case, we might argue based on this, they should be more collaborative. What she discovered in her research was that the teens that were reporting the higher error rates that were actually occurring, the nurses felt comfortable talking to the doctors.

The doctors felt comfortable talking to the nurses and alerted each other to errors or mistakes. We're going to start moving away from comfortability to safe. They felt safe, whereas the nurses and doctor teams where that wasn't the case where nurses feared. I'm going to use the word because her book is titled *The Fearless Organization*. They had a real fear of bringing up mistakes.

Now, we talk about ethics. This is happening inside an emergency room, inside a hospital where, absolutely, if there are mistakes made, you want this to be reported so you can correct these mistakes. The nurses had a fear of bringing up these issues with the doctors. This is what was discovered. This is psychological safety. The definition? A shared belief that the team is safe for interpersonal risk-taking.

If we dive more into what happened with these nurses and doctor teams, what happened with the nurses and doctors and, specifically, the nurses that were either finding errors, making mistakes themselves, and should have reported this, why weren't they? When Dr. Amy Edmondson investigated this, it was a real fear like a fight-or-flight response, an anxiety to speaking up, to sharing this information with the doctors and the administration. It was a lack of safety.

What Dr. Amy Edmondson uses as a term is "speaking up," did not feel comfortable speaking up. You have to rationalize this. We talked about the fraud risk triangle, which I'm sure you're aware of with this audience here. There has to be a rationalization to this. What Dr. Amy Edmondson termed it as was "discounting the future" because there are real consequences in a hospital.

People's lives are at stake for nurses and doctors not to identify and correct mistakes. The nurses said to themselves or thought to themselves, "You know what?" The immediate term of getting the consequence of potentially telling and disclosing these errors was so much a fear for them that in their mind, they said, "You know what? This is not a big deal, not as big a deal as I'm making it to be, and also this might not happen again.

That's where "discounting the future" term arises that the nurses and doctors, and specifically the nurses would say, "Someone else will catch this down the line or this is unlikely to happen again. No need to report it." You can already see the relationship here to ethics. Now, Dr. Adam Grant, who is a professor of organizational psychology at the Wharton school of business, very prominent. He has the *WorkLife* podcast.

He's all over the news because he's very clinical and data-driven. That appeals to our type of audience, right? Fraud examiners, CPAs. He put this out as a tweet and also on LinkedIn to help us understand psychological safety. Now, this is where Dr. Amy Edmondson works a lot. This is her specialty, but the work of Dr. Adam Grant, which is on the meaningfulness of work, creativity, definitely ties into psychological safety.

He tweeted this, "Psychological safety is not relaxing your standards, feeling comfortable, being nice and agreeable, giving unconditional praise. Psychological safety is a culture of respect, trust, and openness where it's not risky to raise ideas and concerns." That's what Dr. Adam Grant would describe it as. We had the definition. It's about feeling safe. The question is, what do you get for this?

You might be thinking organizationally or as a leader, what do you get? Well, first, start about what you lose. What do you lose if you don't have this? Prior to the pandemic, I flew a lot. I was a traveler. A lot of what I did is professional speaking, so I'm on the road. What happened to Boeing, the two crashes with the 737 Boeing MAX, when they happened, the first crash was on my radar because I travel a lot. I have some travel anxiety, so I was like, "Oh, my gosh."

When the first crash happened, it was attributed to pilot error. Then a second crash happened a couple of months later. An investigation was done and it wasn't pilot error. They grounded all the 737s. I was grossly interested what happened with Boeing because I had done case studies on Boeing when I was a student. Boeing was just a safety-first organization, producing quality airplanes and always thinking quality and safety.

As we understood what happened with the 737 and the quality overlap, the lack of quality that happened with their new production of the 737, I wanted to know what happened because my perception of this organization from the outside was that they would do everything quality. Obviously, they're a profit-seeking organization but quality and safety first. Well, that was the organizational culture, but organizational cultures can change.

They had a new executive branch that came in and they were facing competition from Airbus. This has been documented through many investigative journalism and also through the congressional hearings in the US with the former CEO of Boeing. Boeing's real strategy changed towards getting production and getting these planes out to compete with Airbus. Airbus had equivalent 737 passenger jet, which was taking up some of their market share.

Through discussions and postmortem, so this all happened postmortem, we had two planes that crashed and people died on those planes. It was amazing to hear the sad cultural shift from quality. This was really epitomized by the quality managers. This is also, again, the postmortem of all this in hindsight. The

quality managers described in the aftermath, a culture that was the culture we might have understood with Boeing.

If there was a quality control issue-- and this was at Washington State. At the time they moved the production branch, they moved to North Carolina. If there was an issue, the quality manager there could stop production like that. They felt safe and empowered to stop production on these planes and go, "No, I know this might delay the shipment, but we have an issue. We have a significant issue or a small issue."

It doesn't matter what the issue was. They felt that they could speak up. They felt safe. How quickly that changed in the interviews that we're after to a place where that was not prioritized. In fact, quality managers were meant to feel unsafe to bring up issues if it delayed production. The issue with these planes is that they have this automated navigation system called the MCAS system that was developed for the 737.

They were also cost-cutting. The quality managers and all the individuals that were involved understood there was an issue with these. It's multiple sensors on a plane that indicated the plane needs to be course-corrected by an automated system, but there's usually multiple sensors. The cost-cutting and other issues resulted in there being only really one sensor on the plane.

There were also multiple other problems. I don't want to bring up a fear of flying. If you listen to the podcast, the New York Daily podcast with those that were describing the situation with Boeing after these plane crashes happened, how unsafe they felt, it doesn't necessarily make you feel safe to travel. What happened with these sensors is that there was only one on the 737.

In both cases, anything that could happen to that one sensor could cause a problem with the sensor, thinking that the plane was either going up or going down incorrectly. They believe it's most likely a bird strike that hit the sensors. What happened was that the sensors thought that the plane was going up. It took over the plane, the MCAS system, and pushed the plane down.

The pilots were unable because of all kinds of engineering deficiencies, all kinds of oversight. People who actually knew and didn't speak up, they couldn't override the plane, which they should have been able to. The plane nosedived and crashed. It was horrible, horrific. These are the two really negative stories where when we look at hindsight, we just wanted someone to speak up. Because along the way, this could have ended differently.

Individual ethics can be compromised with situations where there is low organizational, psychological safety. If you do get information that psychological safety is low within an organization or team, hopefully, I made the argument that for ethical decision-making, for just decision-making in general, for creativity, employee engagement, we want to improve it across all three levels of the organization leader and team.

Coming back to Dr. Adam Grant's tweet, it's not about relaxing your standard or feeling comfortable or being nice and agreeable about giving unconditional praise, but a culture of respect, trust, and openness. I have some ideas. This is not an exhaustive list and this is not causation. You do this, psychological safety will go up. If it was, again, it would be just simple and communication is hard, but some ideas as you as a leader, the team, and the organization.

If you're a leader of teams, you are in the best position to improve psychological safety. Teams themselves that are at the same level, a little bit harder. Organizationally, that takes more work. What are some things you can do if you assess psychological safety as low? One, make the assessment as a leader of a team. Do an assessment, do the work in the materials, take in information from the viewpoint of psychological safety that might indicate to you that psychological safety is low.

Let's take the KPMG work. Emphasize purpose. What is the purpose of the team? What is their goal? What are they trying to do? Doing a very basic level can help the team members feel safe. To meet that end objective, they need to speak up. Demonstrate situational humility, which is a really important one.

This is what Dr. Amy Edmondson saw with the doctors and nurses that reported errors. The doctors would say they made a mistake.

Situational humility occurs when the leader says, "I made a mistake. I want to let the team know to show an example that you can speak up because I'm showing myself to making mistakes as well." That can also remove and destigmatize the fear of failure and express appreciation. Not just unconditional praise, but where it's warranted, but positive feedback can go a long way to improving psychological safety.

Within the team, a team mission statement that actually echoes the real goals of the team. We talked about Boeing's mission statement and Wirecard and CyberFund. They didn't live their mission statements. They clearly had another mission statement and employees understand that. The team mission statement is the mission statement. It doesn't have to be the technical one to get a project done. It might be something else that really has the team feeling safe to move towards those objectives.

Setting up the structures and processes, I'll talk about that shortly as an example, and measuring performance can help. At the organizational level, setting the tone at the top can help the mission statement that is clear but also lived. It's not a mission statement that is being incongruently, "Here's a mission statement and here's what we're doing." Boeing would be the example of that, and destigmatizing failure.

Listen, people make mistakes and some mistakes are not correctable by our employees. If people fear mistakes being made like those doctors and nurses, they will not speak up and you will not be able to identify and maybe make a change or course-correct. Other things can happen within the organization. To really have this dialogue around this, the dialogue is really key. I did want to talk about setting up structures and processes within a team as I come to my conclusion.

This has been recent as a discussion point like psychological safety and videoconferencing. I work in the training space. A lot of people in the training space if they're leading a webinar are like, "Have your cameras on. We need your cameras on, cameras on, cameras on, cameras on if we're on Teams, we're on Zoom, we're on ON24." Now, I was anecdotal, but research is supporting this.

Minorities, First Canadians, and women can have a level of anxiety. This was posted by Adam Grant and research linked-- It's on my LinkedIn feed if you want to see it, can actually make people feel really unsafe if there's not a reason to turn the camera on other than for the presenter. This is what I mean by setting up structures and processes. Sometimes we just assume because we're just learning about videoconferencing, not the technology but how to use it effectively.

We can make people feel very unsafe in this mode. If we don't think, why are we using the camera on? This is because it's a sense of community with our teams. If somebody doesn't feel comfortable with their camera on and the research pointed towards women and minorities in particular, maybe we should do it with thought instead of structures and processes and really get feedback as to where psychological safety is around using technology.

Just something to think about. I have changed my thought process around it. I used to be a little bit, "Hey, it's a webinar. We're talking about the audit standards. We're talking about artificial intelligence or blockchain. These are topics I talk about. Let's turn on our cameras." Really, for me, it was a bit ego-driven because as a presenter, the cameras are on. I get to see non-verbal, but we really should be thinking about our team. That's what I mean by setting up structures and processes.

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Sarah: Thank you for listening. You can find this podcast along with all other episodes of *Fraud Talk* on acfe.com, Spotify, iTunes, or wherever you listen to your podcast. This has been Sarah Thompson signing off.