Reflections

The SoL Journal
on Knowledge, Learning, and Change

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society for SoL
organizational learning

30 Years of Building Learning Communities
A Dialogue with Peter Senge, Otto Scharmer,
and Darcy Winslow, Part 2

What story will children 75–100 years from now tell about how our current generation managed the tremendous large-scale challenges we face? And how can we – as individuals and communities – begin to change our trajectory so that the narrative our descendents weave is one of renewal rather than of destruction? In part two of their dialogue on the role of cross-organizational communities such as SoL and the Presencing Institute in a changing world, Peter Senge, Otto Scharmer, and Darcy Winslow look at the need to renew civilization from its roots rather than attempting to fix our broken institutions. They explore ways we might join together to "open a crack to a future that is different from the past" – and in the process create a genuinely "flourishing" society.

Choice As a Leadership Capability
Rawlinson Agard

Many people in organizations today live a dual life: they understand the power and importance of new ways of leading – such as those based on the principles of organizational learning – but they are hesitant to rock the boat by introducing these concepts in their organizations. For many years, Rawlinson Agard found himself in this same situation. Even as he worked to bring large-scale change to the complex systems he was a part of, he found that his actions and purpose were out of sync. A health crisis prompted Rawle to reflect on his choices – and set a new course of action that would bring together the two disparate threads in his career. In this article, he asks us to consider our own choices as we strive to make this world better for all.

Is Moving Too Fast Slowing You Down? How to Prevent Overload from Undermining Your Organization's Performance
David Peter Stroh and Marilyn Paul

Organizational overload is a problem confronting people across all industries and sectors. People have too much to do in too short a time with too few resources to accomplish their goals. The result is that managers find it difficult to sustain focus on and implement top organizational priorities. This article uncovers the root causes of organizational overload and targets the ways in which organizations unwittingly increase overload and crises in their continuous efforts to accomplish more with less. In particular, it exposes the ironies of a "can-do" culture that leads people to work harder at the expense of achieving consistently strong results. The authors conclude by recommending how to build a "results and renewal" culture to achieve higher, more sustainable performance.

From Automatic Defensive Routines to Automatic Learning Routines: The Journey to Patient Safety
Michael Sales, Jay W. Vogt, Sara J. Singer, and Jeffrey B. Cooper

Patient safety in hospital settings is a major public health problem. Several distinctive challenges combine to create a high-risk environment for patients that can result in grave – and costly – personal and organizational consequences. The authors hypothesize that defensive behaviors among hospital leaders, managers, and staff aggravate the dangers implicit in these settings. In this article, they describe a multidimensional training program, Healthcare Adventures™, in which the exploration of so-called "automatic defensive routines" figures as an important focus. This intervention combines a simulation of a traumatic patient safety event with structured reflection. Taken together, these kinds of learning opportunities support collaborative inquiry and appreciative engagement, which in this case can improve outcomes for patients.

Teaming Is a Verb

Amy C. Edmondson

Organizations thrive, or fail to thrive, based on how well the small groups within them function. In most organizations, the pace of change and the fluidity of work structures mean that success no longer comes from creating effective teams but instead from leading effective *teaming*. Teaming occurs when people come together to combine and apply their expertise to perform complex tasks or develop solutions to novel problems. Fast-moving work environments need people who have the skills and the flexibility to act in moments of potential collaboration when and where they appear; that is, people who know *how to team.* As summarized in this excerpt from *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy,* four behaviors – speaking up, collaboration, experimentation, and reflection – are the pillars of effective teaming.

From Automatic Defensive Routines to Automatic Learning Routines
The Journey to Patient Safety

MICHAEL SALES, JAY W. VOGT, SARA J. SINGER, AND JEFFREY B. COOPER

Patient safety in hospital settings is a major public health problem. Several distinctive challenges combine to create a high-risk environment for patients that can result in grave – and costly – personal and organizational consequences. The authors hypothesize that defensive behaviors among hospital leaders, managers, and staff aggravate the dangers implicit in these settings. In this article, they describe a multidimensional training program, Healthcare Adventures™ in which the exploration of so-called "automatic defensive routines" figures as an important focus. This intervention combines a simulation of a traumatic patient safety event with structured reflection. Taken together, these kinds of learning opportunities support collaborative inquiry and appreciative engagement, which in this case can improve outcomes for patients.

Michael Sales   **Jay W. Vogt**   **Sara J. Singer**   **Jeffrey B. Cooper**

Patient safety errors in hospitals are a significant public health issue in the United States and elsewhere. As this sampling of statistics demonstrates, the data is sobering:

- According to a 1999 study by the Institute of Medicine, 44,000 to 98,000 deaths occur annually due to preventable patient safety errors.[1]
- HealthGrades, which describes itself as "the leading independent health care ratings company," believes that these numbers dramatically understate the problem, estimating that "an average of 195,000 people died" annually in the early years of the century and that the data hasn't changed that much since.[2]
- Hospital-acquired staph infections in 2005 reached 478,000, representing an increase of 62% from 1999.[3]
- A 2012 Johns Hopkins study estimates that in the United States, surgeons leave foreign objects such as sponges and towels inside patients' bodies after operations a minimum of 39 times a week; perform the wrong procedure on patients 20 times a week; and operate on the wrong body site 20 times a week. The cost of these errors is more than $1.3 billion in medical malpractice payouts, and the reporting systems to capture these events are inadequate.[4]

Something is tragically wrong when hospitals, which are supposed to protect the vulnerable, all too often put them in jeopardy. Teams of professionals in other high-consequence industries, such as commercial aviation, deliver a more reliably safe experience to consumers than hospitals.[5] Why have hospitals generally been unable to overcome safety challenges? How should training programs be designed to help address this disturbing situation?

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Challenges to Team Learning

Obviously, hospital executives and administrators want patients to be safe, and they want to avoid the pain, cost, and damaged reputation associated with preventable errors. However, while hospital managers are well placed to improve patient

safety, they often lack the training necessary to provide leadership in this area. Those in non-clinical roles generally have little or no patient care experience and are not exposed to the safety issues confronting frontline workers. Clinicians who assume substantial administrative responsibilities spend little time in actual patient care. They may lack familiarity with clinical roles other than their own. In addition, clinician-managers may not have received management training. Further, patient care occurs within the context of complex business, economic, and political environments that present hospital leaders and managers with a wide range of competing and sometimes conflicting priorities.

Healthcare managers often work in teams. Relative to other industries, creating a team learning approach to safety is impeded in hospitals in several ways:

- Hospital managers' differentiated responsibilities can prevent them from managing hospitals as systems.
- Technically proficient healthcare professionals aren't trained to work together in groups or in

teams. They are trained primarily to rely on their individual expertise to prevent failures.

- Differences in training and focus across disciplines often yield different perspectives and interpretations of events, which can make it challenging for cross-functional groups to work together.
- Hospital environments are not standardized and are not designed as systems. New ways of working are often added on with little thought given to how they integrate with the rest of the system.
- The extensive clinical training of clinician-managers may cause them to focus more on promoting technical remedies than on cultivating a team learning orientation.
- Conversely, because managers who are not clinicians lack clinical experience, they may believe that interventions to promote patient safety are beyond their expertise or influence.
- Medicine is an inexact science, and every human body is unique.
- Patients are sick, and families are under stress, which adds another layer of difficulty to critical information exchanges.
- Many information hand-offs in hospitals take place between people with radically different roles and training. The lack of standardization in these transfers often leads to communication breakdowns.
- Personnel in hospitals are under huge pressure to produce more with fewer resources.

These factors can turn healthcare institutions into stressful environments that incline practitioners and work units away from personal connection and collective reflection. People are constantly on the move, dealing with challenging and frequently life-threatening problems. Interactions are often transactional, resources and staffing are constrained, and people are encased in disciplinary and administrative silos. These conditions are fertile ground for defensive, competitive, impersonal relationships. Unnoticed and untreated, such defensiveness creates a climate that inhibits hospitals from taking a learning stance toward the systemic causes of patient safety problems.

Organizational Culture and Automatic Defensive Routines

In the early 1970s, Chris Argyris and Donald Schön introduced the "theory of action" perspective, an analysis of the relationship between personal values, attitudes, and behaviors and the dynamics of organizational culture. By rigorously observing people in action, they demonstrated that many of us hold erroneous assumptions about the values and attitudes that shape our behavior. For example, I may firmly believe that I am open and inquisitive. However, close inspection of my behavior demonstrates that I am actually defensive, that is, closed to being influenced. We all have "espoused theories" regarding the principles we believe are guiding our actions, but the "theory-in-use" that can be inferred by analyzing what we actually do often looks quite different.

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In organizational settings, the gap between what we think of ourselves and what our behavior says about us is "undiscussable" because, as far as we're concerned, it does not exist. Since we share with our coworkers an unspoken agreement not to analyze our behavior, we collude in creating an organizational resistance to awareness.

The mismatch between our espoused theory and our theory-in-use is heightened whenever we experience stress. Consequently, many people manage stressful interpersonal conditions – and protect themselves from uncomfortable self-reflection – by:

- Dominating conversations
- Asserting opinions as facts
- Acting on the belief that they know what others mean without testing their perceptions

- Allowing others to dominate an interaction
- Withholding feelings and perceptions
- Discounting the importance of what others have to say
- Persistently acting in ways that suppress negative feelings – their own and those of others

We are seldom aware of our use of these strategies. They happen at pre-conscious levels. For example, a nurse is guarded as she enters an interaction with a superior. The manager subconsciously senses that lack of trust and responds aggressively. The nurse in turn feels that her guardedness was justified, without realizing that her readiness to be suspicious influenced her manager's behavior.

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Given that we fail to notice many of our thought processes, we tend to act according to "automatic defensive routines" — habitual defensive thoughts and actions that we don't consciously notice. When people within an organization repeat these routines over and over again in many different situations, automatic defensive routines become layered into the cultural fabric. They are produced at every level of organizational action, from group to team to the organization as a whole. Because this behavior is so engrained in the organization's culture, over time, people stop trying to change it. Within this kind of culture of fear and self-deception, people learn how to get along rather than how to discover and solve problems together.

A Patient Safety Leadership Culture

As noted above, healthcare management teams are particularly vulnerable to the organizational pathology of automatic defensive routines. That defensiveness puts patient safety at risk. For example, research indicates that healthcare leadership teams frequently react to the challenges of patient safety with a "seek perfection" rather than a "seek learning" response.[6] Healthcare practitioners tend to be self-reliant by training and impose very high standards on their own performance. This seemingly positive approach often has unintended negative consequences. Given a "seek perfection" orientation, practitioners try to avoid dependency on others, not wanting to be judged incompetent when others make mistakes, or fearing that others will recognize and criticize their own mistakes. When errors inevitably occur, perfectionists tend to hide them to avoid blame. The pursuit of perfection thus amplifies defensive routines. Practitioners learn to be more defensive rather than more oriented toward patient safety.

A "seek learning" orientation leads to a different set of behaviors: people ask for feedback and learn from it, reflect together, and search for systemic solutions. Such a learning stance reinforces behaviors that result in structured, consistent, and persistent organizational inquiry. Drawing on the literature on leading organizational learning, we suggest that to create such a culture in hospitals, leaders must:

- Continuously demonstrate that they "really care" about patient safety
- Manifest a welcoming and non-defensive attitude when engaging in conversations about patient safety
- Encourage everyone involved in patient care to speak up about their concerns
- Facilitate communication about patient safety in both formal and informal ways
- Take visible and tangible action to emphasize the importance of patient safety
- Mobilize and circulate the information that is needed to support patient safety
- Seek input from key stakeholders to get the best thinking and to win support for system changes that support patient well being

These leadership behaviors help to increase interpersonal and intergroup openness and inquiry and reduce the need for people to think and act

defensively. Figure 1 shows the relationship between these leadership behaviors, team learning, and group performance.

In the next section, we describe how certain kinds of intervention can loosen the grip of automatic defensive routines on hospital cultures.

Simulations to Jump Start Hospital Safety

The Healthcare Adventures™ (HCA)[7] program was developed to introduce hospital management teams to patient safety concepts, develop their teamwork, and inspire them to bring these concepts and behaviors into their sphere of influence. The program evolved from earlier versions developed by the Center for Medical Simulation (CMS) and was further refined and evaluated by the authors under a research grant from The Patrick

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and Catherine Weldon Donaghue Medical Research Foundation.[8]

Like the therapeutic jolt of a defibrillator, Healthcare Adventures is intended to jump start safety practices in hospital leadership teams. It uses various modalities – intended to engage multiple learning styles – to shake up entrenched ways of acting and learning. An effort to soften the

FIGURE 1   **The Elements of a Patient Safety Leadership Culture**
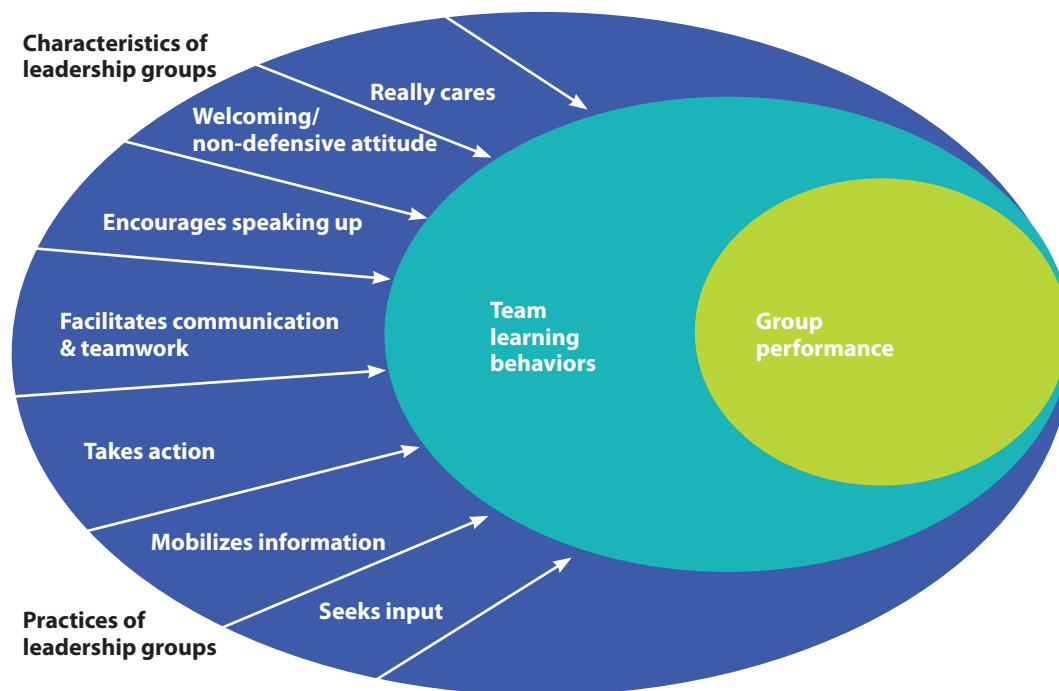
The *characteristics* refer to a set of leadership attitudes and values. Learning-oriented leaders are non-defensive and clearly make patient safety a top priority. One of the ways they demonstrate their openness is by encouraging others to speak up. They are inveterate team builders, always looking to create learning conversations. The *practices* refer to leader behaviors related to specific patient safety efforts, such as supporting a programmatic innovation, gathering and circulating information relevant to an initiative, and seeking input and support from key constituencies.

dynamics of automatic defensive routines is woven into each element of the intervention.

The Center for Medical Simulation has run this program with 16 teams of hospital administrators, leaders, and executives from several hospitals. The teams have been composed of clinicians, non-clinicians, and mixtures of the two. Team members start off a full day of training by taking part in a moderately stressful simulation of a hospital event highlighting patient safety. The team then uses the "Gameplan," a project planning methodology, to reflect on its own behavior while improving patient safety. Prior to the training day, team

TABLE 1   **Training Elements and Their Impact on Automatic Defensive Routines**

Training Element	Description	Impact on Automatic Defensive Routines
Pre-meeting with team leaders and/or entire team	A 90-minute meeting to understand issues confronted by the team and to establish a project focus for the full-day training session	Heightens awareness of team dynamics, particularly regarding topics that might be both important and "undiscussable," e.g., conflicts over the priority paid to patient safety
Training Day Element 1: Appreciative Inquiry	A 30-minute reflection by the team on instances when it has been successful in identifying and addressing patient safety challenges	Establishes pride among team members in their accomplishments, thus strengthening their ability to engage controversial issues in a respectful fashion
Training Day Element 2: The Simulation	A 30- to 60-minute experience that provokes and reveals underlying team dynamics	Provides the facilitators with directly observable data of the team in action that they can then use for inquiry and discussion
Training Day Element 3: Debrief	A 60-minute discussion of what happened in the simulation	Explores the difficulties people have in speaking up and the challenge of mixing advocacy and inquiry. Provides "teachable moments," i.e., opportunities to observe and reflect on defensiveness and openness in real time.
Training Day Element 4: Theory	A 30-minute presentation and discussion of the Patient Safety Leadership Culture framework (See Figure 1)	Provides a theoretical framework for recognizing the interpersonal and leadership skills necessary to produce collective learning regarding patient safety
Training Day Element 5: Survey results (when a survey of leadership for patient safety has been conducted)	A 30-minute presentation and discussion of the results of a unit-wide survey that reports on the perceptions that the entire organization has of the leadership team's commitment to patient safety	Frequently provokes the complaint that the survey instrument was flawed, which is often followed by an acknowledgement that the leadership team has something to learn that might make it uncomfortable
Training Day Element 6: The Graphic Gameplan	A 2- to 3-hour planning process that results in a shared approach to an important patient safety initiative, focused on what leaders can do to support its implementation. Over the course of this session, the group fills in the elements of a Graphic Gameplan (see Figure 2) to create a visual roadmap to guide its initiative.	Provides an opportunity to apply the lessons learned during the activities of the day to a meaningful leadership team undertaking; specific responsibilities for taking action, mobilizing information, and seeking input related to the project are assigned to team members
Post-training day evaluations by facilitators	A brief assessment of the team's learning during the course of the day leading to follow-up planning	Identifies specific competencies that the facilitators think the team ought to concentrate on
The Booster Shot	A 2-hour discussion about the state of the team's project and its learning about leadership that occurs 1 to 6 months after the training day	Stimulates team members to remember what they learned and to hone the behaviors with which they've been experimenting

FIGURE 2   **The Healthcare Adventures Graphic Gameplan**
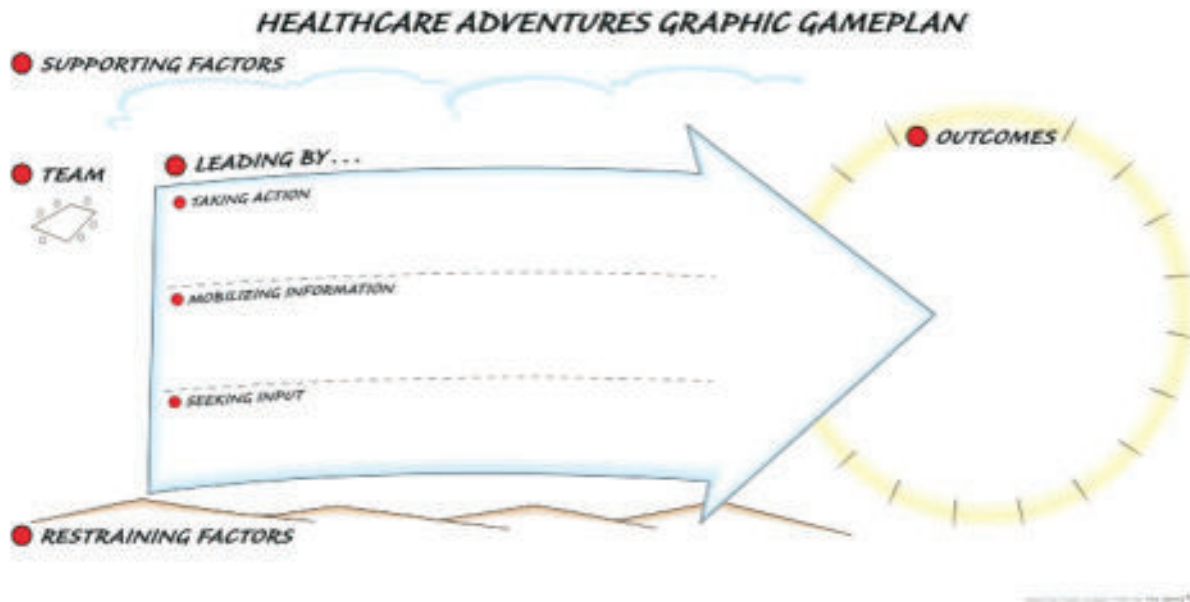
Using the Graphic Gameplan, a leadership team envisions the flow of a patient safety improvement initiative from start to finish in a way that points out the specific steps needed to achieve the desired outcomes.

leaders or the entire team meet to learn about the general nature of the training and discuss the team's needs and goals. The training day is followed by a "Booster Shot" at some later time to check in on the team's learning and its progress.

The simulation begins when a member of the CMS instructor team enters the room in a lab coat or scrubs. Employing some form of theatrical deception (e.g., "I'd like to take you on a tour of the hospital we just acquired"), the instructor invites participants to join him or her in a learning experience. The participants expect to engage in a simulation, but they don't know the details. They then leave the training room and enter a simulated hospital space.

CMS has used two simulations in the Healthcare program:
• Participants assume roles in which they assist a surgeon (a trained actor on the CMS staff) who discovers – unhappily – that he or she has operated on the wrong knee of an elderly patient. The members of the teams that engage in this simulation are typically non-clinicians who are

given enough training to take on the roles they are asked to play.
• Participants assume roles in which they are the leadership team of a large, prestigious hospital that is visiting the emergency room of a smaller, less well-run facility it has just acquired. The emergency room has patients in two beds. The husband of one of the patients (both the husband and the patient work for CMS) inadvertently – and inappropriately – makes a video recording of a physician and a nurse (also actors) as they make a series of errors with another patient (a mannequin) in the neighboring bed. The participants in this simulation are typically clinicians asked to perform a managerial function.

Both simulations last about 30 minutes. In the first case, the surgeon is enraged that the mistake has been made and harangues others for causing the problem. As a result, the surgeon pushes for actions that may be ethically questionable. Do any members of the participant team speak up as advocates for the patient and her family? In the second case, after the emergency room scenario,

the team receives an urgent request from the president of the acquired hospital to help respond to the anticipated avalanche of negative publicity resulting from the threatened release of the video to the media. The team is given 30 minutes to develop a plan.

Both simulations provide an opportunity for the training group and the facilitators to observe the team's dynamics. These reflections typically include discussion of automatic defensive routines, their repercussions, and ways that people might act differently.

Learning activities are organized around the simulation, each of which reinforces the messaging on automatic defensive routines. Table 1 (p. 36) describes each component of the training program and its impact on automatic defensive routines.

The team dynamics made visible in the simulation provide observable data for conversation and reflection during the remainder of the training day.

An Illustrative Vignette

The team dynamics made visible in the simulation provide observable data for conversation and reflection during the remainder of the training day. The group looks at the presence or absence of four critical leadership team characteristics regarding safety: "Really cares about patient safety," "Encourages speaking up," "Is welcoming and non-defensive," and "Facilitates communication and teamwork." Each of these behaviors is an antidote to automatic defensive routines. The facilitators heighten participants' awareness of the behaviors and mental models that contribute to defensiveness and poor communication around patient safety, and those that lead to collective learning and improved performance.

In the following example from a Debrief, we see a group that participated in the emergency room scenario discussing the observation that one or two team members did most of the talking during the event:

Facilitator [to a female participant who is a nurse]: "At the beginning of the ER simulation, you said something about the presence of the video camera. Your team leader [a renowned male physician] immediately said, 'Is his using the camera a problem? Maybe it is a bonus to have the recording going on.' What did you feel when he said that?"

Participant, with emotion: "My feeling was my statement wasn't valued. I recognized his point, but my thought was that there were major HIPAA things going on here [HIPAA is an acronym for the Health Insurance Portability and Accountability Act, which protects personal health information]. It made me feel downtrodden."

Facilitator: "This was the first place where that opening to discuss possible HIPAA violations appeared, and we never found more about your concerns because of that exchange."

The physician who had interrupted her comments, clearly regretting his action: "What happens is you lose track of the problem. Somewhere you have to record it so you go back to it. It wasn't the camera, it was the HIPAA issue we have to address. But we didn't get to that because of the way I responded to her."

A nurse educator, who had also moved the group's attention away from the HIPPA comment: "I feel like I devalued what she said, and I did it consciously. I was like 'We have a huge issue here [with another aspect of what was going on in the simulation]!' So I wanted to change the subject. I felt I was totally clamping you down. I knew I was doing that. Should I have gone back later on and undid that?"

Another participant: "I felt like I didn't have a lot to say because the overarching issue was this guy in the other bed was going to die. I'm usually the one that brings up the underlying personal issues, but I thought that we had a more important issue: the condition of that patient. Those clinical things are easier to deal with because they are what we do. That's easier than working through the human affect stuff."

The nurse who had raised the HIPAA concern: "But we look to you for that! That is your area of expertise. There are times I really wish you would speak! There are times people are thinking it and not saying it *[a lot of emotion in her voice]*."

The unit's director of nursing: "Conflict avoidance is inherent in most of us. It is, 'what is your threshold? What is going to push you to the point to say something?'"

Here, an internationally respected surgeon at the top of his field, who is very assertive and proud of being "right," publicly acknowledges that his behavior prevented a subordinate from speaking up. A nurse confronts a colleague about her not speaking up. A director of nursing reflects on people's tendency to avoid conflict by not speaking up. During the Appreciative Inquiry exercise at the beginning of the training day, the members of this team expressed pride at their patient safety accomplishments. But at this moment in the training, they all opened up to a deeper level of reflection on the limits of their team dynamics, which did not conform to their more polished story of themselves. This openness later paid off in an energetic and comprehensive discussion by the team of an important patient safety project during the Gameplan module. At the close of the day, the nurse who raised the HIPAA issue described the impact of the training as "reminding us of the importance of being respectful to one another and using inquiry to solicit other people's opinions."

Without a focus on overcoming automatic defensive routines, most hospital teams will act more defensively than they realize and than their patients would want.

Collective Learning

Healthcare Adventures™ aims for an ambitious result: to make automatic defensive routines visible, to reduce the inclination of participants to use them, and to point them toward automatic *learning* routines, like speaking up about patient safety. Chris Argyris and his collaborators have demonstrated that defensive routines cannot be easily "unlearned." Because they are habits of self-protection that individuals and groups automatically use when they feel threatened, they usually operate below conscious attention. Even when we are conscious of them, we find it challenging to pause and say things to ourselves like, "Hmm, I should listen more closely to what this other

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person is saying. I know I don't like him or his way of thinking, but maybe there's something there." Most of us require time and effort to learn to concentrate in this way. It is presumptuous to believe that a single training program, no matter how effective, can lead to the permanent transformation of defensive routines into ones that promote collective learning. But we can be sure that, without a focus on overcoming automatic defensive routines, most hospital teams will act more defensively than they realize and than their patients would want.

Programs like Healthcare Adventures create an environment where the members of a team can celebrate their achievements and learn about themselves individually and collectively in a way that promotes non-defensive values, attitudes, and behaviors. Sometimes this shift is dramatic:

• One group did not finish the task of preparing an action plan for the CEO after members visited the emergency department. When the facilitator pointed this out, they reacted defensively. Suddenly, one member of the group

spoke up (over multiple interruptions) and said, "What just happened in the simulation isn't that unusual. You know, I'm a trained facilitator who has the ability to help this group complete its tasks. But, I don't feel empowered in this group. I feel like I defer to people who are more influential and have higher rank, and as a result, I'm not well used by the group, and the group isn't taking advantage of my expertise." You could have heard a pin drop when this professional said something that had been on her mind for a long time.

In other instances, the impact is more subtle:

• The nursing director of a group acknowledged how defensiveness among the managers had caused his staff to stop offering suggestions. Describing the previous week, he said, "We had a new staff person who joined medical services. After offering new ideas, he said 'I'm not going to do this anymore because everyone gets defensive and shuts down.'" This remark led to extensive discussion about what it would take to be truly welcoming of input regarding patient safety.

• As a result of the training, culture shifts. Here's a report from a "Booster Shot" meeting: "We say 'Let me see what we can do to help.' We're doing more of this now than before. People are seeing us more for that and coming to us with questions. I see people going above and beyond to help people."

• A leader of one group described using a lesson from the training program to promote speaking up: "If it's the right thing to do, you need to speak up. … I've used that example [from the training program exercise] so many times to explain to people the organization chart doesn't matter. I have some responsibility for patient safety just by being physically present."

The Healthcare Adventures program is designed to soften automatic defensive routines by turning hospital leadership teams toward reflection and inquiry. Research by Singer and colleagues tracked qualitative data on 12 of the teams that have experienced this training, identifying the charac-

teristics of high performers, i.e., those teams that used the program to deep advantage. She has found that high-performing teams come primed to learn from their experiences and make time to confer with each other in a structured and persistent fashion. Low-performing groups tend not to engage in reflection and don't characterize their team as one where people appreciate and respect each other. Yet, this kind of training prompts leaders even in the low-performing teams to reflect together in real time. Therefore, all teams use their reflections to some extent to discuss how their particular constellation of beliefs and behaviors affects the quality of their leadership, and ultimately, patient safety.

In high-performing teams, the training process intensifies leaders' interest in listening to others in order to learn. In low-performing teams, it opens the door to the sort of conversations that the team has been avoiding. In mid-range teams, it shows what the results of greater awareness and openness culture could be. For all teams, however, training like that provided by Healthcare Adventures provides tools that participants can use to promote patient safety. While not every healthcare leadership team will want to have in-depth and non-defensive conversations about patient safety, most of us want to be treated in hospitals by teams that do. ■

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ENDNOTES

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7   Healthcare Adventures is a trademark of the Center for Medical Simulation, a 501(c)3, non-profit research and training organization located in Charlestown, MA: www.harvardmedsim.org

8   The Donaghue Foundation is a charitable trust based in Connecticut that provides grants for medical research of practical benefit: www.Donaghue.org

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