

TOASTMASTER®

December 2010

Crisis Leadership

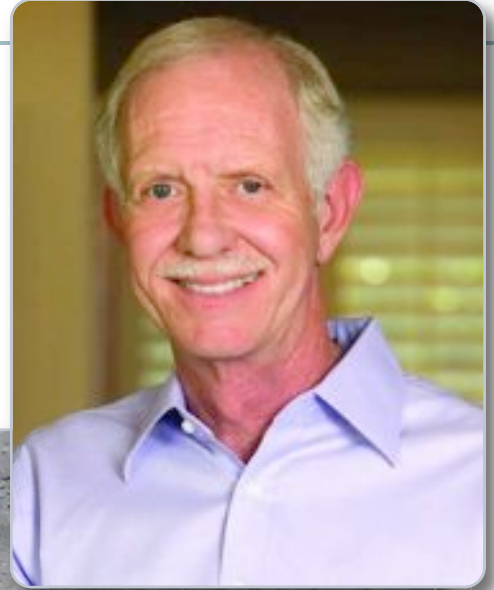
Thoughts on teamwork from
Miracle on the Hudson pilot
Captain Sullenberger

Levity on
Capitol Hill

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Politicians
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Crisis Leadership:

A Leader's Highest Duty



Thoughts on teamwork from Captain Sullenberger, pilot of US Airways Flight 1549.

By Craig Harrison, DTM

Editor's note: *On January 15, 2009, pilot Chesley B. "Sully" Sullenberger III masterfully landed US Airways Flight 1549 on New York's Hudson River just minutes after takeoff from New York's LaGuardia Airport. The passenger plane's twin engines were disabled after it struck a flock of Canada geese. In what has been dubbed "The Miracle on the Hudson," Captain Sullenberger's skillful leadership of his crew and expert piloting saved the lives of all 155 people onboard the jetliner.*

*A 59-year-old resident of Danville, California, Sullenberger retired in March after a 30-year aviation career with US Airways. His story may soon be on the big screen: Producers have optioned the movie rights to his memoir, *Highest Duty: My Search for What Really Matters*.*

Craig Harrison, DTM, interviewed Captain Sullenberger on an array of leadership topics, including crisis communication, teamwork and the need for continual improvement.

Toastmasters are students of leadership. What can you teach us about leadership in crisis situations? I didn't have time in those incredibly intense 208 seconds from when our airplane hit the birds until we landed in the Hudson River to learn what I needed to learn. I had to have already learned it. I had to have invested the preparation, put in the hard work and paid attention for decades – during thousands of hours of flying time. The same is true in many other areas of our lives, including leadership. It's a daily process.

Does leadership need to be demonstrative?

One of the key tenets of leadership is leading by example – live your life in such a way that your values are apparent. I don't have to tell you what they are, wear a shirt with a slogan on it or display posters on my walls. If you watch me long enough, if I am congruent enough and if my actions and words match enough, then it's really apparent how I live and what I believe. I embody it.

Course Corrections

Toastmasters prepare their presentations, yet things go wrong and they have to ad-lib. How did you balance procedure with ad-libbing?

From decades of practice and constant improvement and learning, we [as a crew] had to have clear priorities in those moments: Fly the airplane first, analyze the situation, see what our options were and then begin to take the most appropriate remedial steps. We only got through the first page of a three-page checklist.

That day, I had deeply internalized values and fundamental skills and knowledge that I had developed over decades that I brought to bear very quickly. They needed to be immediately accessible to me.

Ours was really an exceptional case in terms of airline accidents. We had never specifically trained for what we faced that day: the loss of both engines, so suddenly, so completely, at such a low speed, over such a densely populated area with so little time and so few options.

It Takes a Team to Fly (and Land) a Plane

At times you led crews that you hadn't yet worked with. How did you form a cohesive team with so little practice time?

As the captain – the leader – I always set the tone for what was going to happen for the next four days in a brief pre-trip meeting with our flight crew. I began to open channels of communication, make myself approachable, let the crew know that we were working

together for these common goals on this trip: To get back safely on the fourth day having had as good an experience as we can. We were going to look out for each other. I needed them to be my eyes and ears in the cabin and tell me certain things when I was in the cockpit.

The meeting took only about three minutes. But it took this collection of individuals and quickly formed a crew, a working team. We were trying to front-load the problem and create a team very quickly. And that's what this initial meeting did.

It seems this type of communication would help teams of workers in many fields.

In *Highest Duty* I discuss the concept of Crew Resource Management (CRM). CRM began in the 1980s in the airline industry to address the human performance issue. Part of the CRM process is developing a team.

There are parallels between aviation and other domains, with so many shared analogies – patient safety or oil and gas exploration or nuclear power or aircraft carrier flight deck operations. We're talking about human performance. It should really be no surprise that we find so many similarities.

Isn't great rapport between pilot and co-pilot critical to success?

Indeed. A major airline might have 10,000 pilots, 30,000 flight attendants or more. And it's not unusual at all to team with people you've not only not flown with before, but perhaps never met. That was the case for me and first officer Jeffrey Skiles, whom I met for the first time three days [before the plane accident]. Yet we worked together as if we'd done it for years.

One key to our success: We had this common vocabulary, this common core of experience. We'd each been trained to such a high professional standard that we had become essentially interchangeable.

Safety Communication: Log, Look and Learn

You're the founder and chief executive officer of Safety Reliability Methods, a consulting company that studies past aviation accidents. What can people in other fields glean about safety from your findings?

In aviation we have a formalized process of reporting precursory incidents that can lead to accidents and solving systemic deficiencies before they can become problematic. We also have an institutionalized "lessons learned" process through the National Transportation Safety Board. The results are widely disseminated and they inform our procedures and training.

This process of balancing accountability with learning allows us to not just penalize individual practitioners, but look for root causes and fix them, to prevent them from happening again. That mindfulness – that mindset and that learning process – is something that other domains can certainly adopt.

Regularizing best practices isn't limited to aviation. In medicine now, in patient safety, there's a realization that not everything has to be done on the fly. Some situations are extraordinary, like ours. Most other activities are not extreme crises and can be regularized with five- or seven-step checklists of tasks to do in the proper order every time, whether it's a central line insertion in a patient setting or whether it's how to make a soufflé.

A False Dichotomy Between Cost and Safety **Can cost be a mitigating factor in decisions that impinge on safety?**

Aviation teaches us safety can pay for itself if one is willing and able to take a longer view than American business does, with its short-term financial focus on the next quarter.

- What is the nature of front-line leadership?
- Are supervisors mentors or just disciplinarians?
- What's the gallows-humor joke that everybody knows, that really tells the tale about what your organization is all about, but that everyone is afraid to tell the CEO?
- Does trust exist? Are our employees trusted partners or are they seen to be inconvenient nuisances. Are they valued? Are people listened to or are they simply told?

While championing safety and continual improvement, how can one change an organization's entire culture?

I am fond of a quote from author and University of Southern California professor Warren Bennis: "When leaders treat followers with respect, followers respond with trust."

It's not just the organizational charts that we develop or the procedures we have. It's how we lead and treat people, and how we view each other, that really ultimately makes the difference in whether or not we are able to achieve these efficiencies. This is how we are able to achieve the quality and safety that are good, not only for the outcome, but ultimately for the bottom line.

“We had never specifically trained for what we faced that day: the loss of both engines, so suddenly, so completely, at such a low speed, over such a densely populated area with so little time and so few options.”

– Captain Sullenberger

There's a false dichotomy between cost and safety. Are we willing and able to account for the many costs of not having a quality operation: lack of cooperation, poor leadership, waste, and incidents and accidents? If we really and truly account for them, then safety can pay for itself. Getting it wrong is more expensive than doing it right the first time.

A Culture of Improvement, a Commitment to Safety **How can Toastmasters, in our chosen fields, carry the torch for continual improvement, lifelong learning and the pursuit of excellence?**

Again, leadership is absolutely key. Ultimately we're talking about culture. Dr. Lucian Leape, the father of the medical-patient safety movement, defined it as "the way we do things here." It's our paradigm, attitudes, behavior and how we view our work world and our colleagues. There are several questions one can ask to detect what one's organizational culture is:

How key was your power of focus in navigating your flight to safety?

The power of focus was essential that day. Professional pilots learn to compartmentalize, to leave outside the cockpit all the distractions, the distressing details of our everyday lives, to come to work and simply focus at the task at hand. It's impossible to completely do that. To an even greater extent on January 15, 2009, on flight number 1549 we had to do that – very effectively, very quickly.

You've had ample time to reflect on the cockpit decisions made during those harrowing minutes over New York City. How did you keep your wits about you?

I was very proud ultimately of how much we got done in such a quick time and how well we did it. The three things that I think I did very well that day that made all the difference in the world were:

