

Leadership & Safety Excellence

A positive culture drives performance

By Dan Petersen

WHAT IS “LEADERSHIP”? What is “safety excellence”? How are they connected—or are they? These questions are often asked, yet rarely answered. Speeches on leadership are plentiful—and the ideas expressed often differ from speaker to speaker. Conferences have focused on “world-class safety” or “safety excellence,” yet the excellent companies all seem to achieve it differently. Perhaps the concepts of leadership and safety excellence are not as simple as perceived. This article examines each concept and its relationship to the other.

Leadership

A quote from Gary Yukl’s *Leadership in Organizations* sets the tone for this discussion:

Leadership is a subject that has long excited interest among scholars and laypersons alike. The term connotes images of powerful, dynamic persons who command victorious armies, direct corporate empires from atop gleaming skyscrapers or shape the course of nations. Much of our description of history is the story of military, political, religious and social leaders. The exploits of brave and clever leaders are the essence of many legends and myths. The widespread fascination with leadership may be because it is such a mysterious process, as well as one that touches everyone’s lives.

Why do certain leaders (Gandhi, Mohammed, Mao Tse-tung) inspire such intense fervor and dedication? How did certain leaders (Julius Caesar, Charlemagne, Alexander the Great) build great empires? Why were certain leaders (Winston Churchill, Indira Gandhi, Shah of Iran) suddenly deposed, despite their apparent power and record of successful accomplishments? How did certain rather undistinguished persons (Adolf Hitler, Claudius Caesar) rise to positions of great power? Why do some leaders have loyal followers who are willing to sacrifice their lives for their leader, and why are some other leaders so despised that their followers conspire to murder them?

Questions about leadership have long been a subject of speculation, but scientific research on leadership did not begin until the 20th century. The focus of much of the research has been on the determinants of leadership effectiveness. Behavioral scientists have attempted to discover what traits, abilities, behaviors, sources of power or aspects of the situation determine how well a leader is able to influence followers and accomplish group objectives. The reasons why some people emerge as leaders and the determinants of the way a leader acts are other important questions that have been investigated, but the predominant concern has been leadership effectiveness (Yukl).

The term leadership means different things to different people, making its meaning ambiguous. This confusion is compounded by the use of other imprecise terms such as power, authority, management, administration, control and supervision to describe aspects of leadership. After surveying the leadership literature, Bennis, et al conclude:

Always, it seems, the concept of leadership eludes us or turns up in another form to taunt us again with its slipperiness and complexity. So we have invented an endless proliferation of terms to deal with it . . . and still the concept is not sufficiently defined (Bennis, et al).

It seems there are almost as many definitions of leadership as there are persons who have attempted to define the concept. It has been defined in terms of individual traits, behavior, influence over others, interaction patterns, role relationships, occupation of an administrative position and perception by others regarding legitimacy of influence. Representative definitions include:

- “Behavior of an individual when he is directing the activities of a group toward a shared goal” (Hemphill and Coons).

- “Particular type of power relationship characterized by a group member’s perception that another group member has the right to prescribe behavior patterns for the former regarding his activity as a group member” (Janda).

- “Interpersonal influence, exercised in a situa-

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tion, and directed, through the communication process, toward the attainment of a specified goal or goals" (Tannenbaum, et al).

- "Interaction between persons in which one presents information of a sort and in such a manner that the other becomes convinced that his outcomes . . . will be improved if he behaves in the manner suggested or desired" (Jacobs).

- "Initiation and maintenance of structure in expectation and interaction" (Stogdill).

- "Influential increment over and above mechanical compliance with the routine directives of the organization" (Katz and Kahn).

- "Process of influencing the activities of an organized group toward goal achievement" (Rauch and Behling).

This article examines the concept by exploring the process leaders use when dealing with safety. In safety, the specified goal is injury prevention and reduction. Thus, the examination should focus on the interpersonal influence an executive, manager, supervisor or leader can exercise within an organization to achieve that goal.

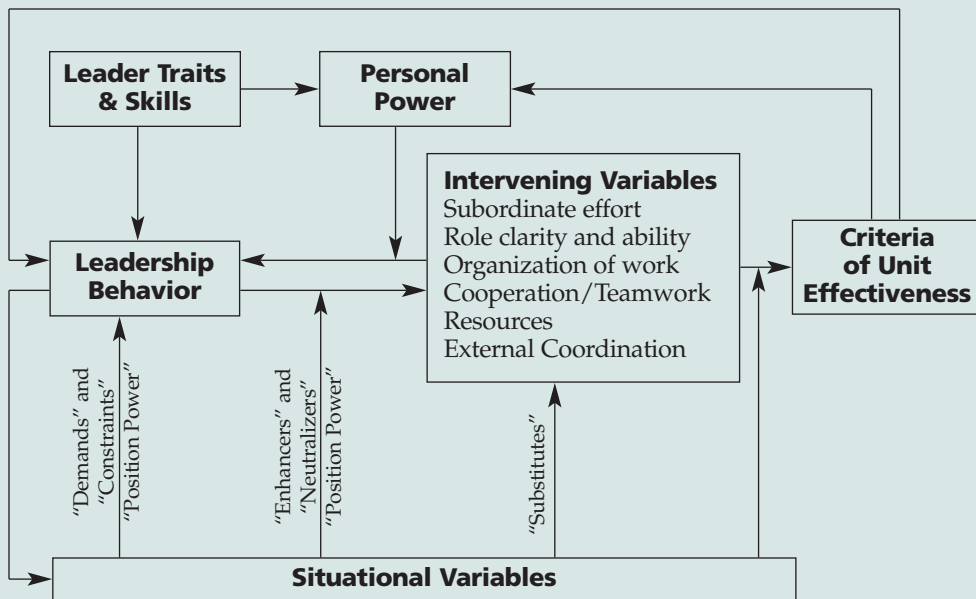
Note that this discussion encompasses "interpersonal influence" and that a "leader" can be not only an executive, but also a "manager," "supervisor" or other position. A leader can be staff or line. The focus is not only on power as defined by organizational structure, but also on the influence a person has within the organization. An SH&E professional can have as much "interpersonal influence" in the organization as any other person. As indicated in *Techniques of Safety Management*:

How much influence or how much power the safety manager represents will depend on the organization and on the personality of the individual in the line position. The safety specialist in any organization obtains results by using one or two methods: 1) making a recommendation to an executive in the line chain of command and that executive issues an order or 2) obtaining acceptance for suggestions voluntarily from line supervisors without taking the chain-of-command route. More often than not, the safety specialist achieves desired results by the second route and uses the first route only for rare emergencies.

Line managers realize that the SH&E specialist has stronger influence than that shown on the organization chart. This specialist is an expert in the field, has certain status, often has

Figure 1

Leadership Effectiveness



Source: Yukl.

management's interest and backing, and likely has some influence on management's appraisal of the line manager and, therefore, his/her future. So, although the SH&E specialist may have no specific authority, s/he is not without power [Petersen(d)].

Figure 1 presents Yukl's conceptual framework of leadership effectiveness.

The model is based on the assumption that organizational effectiveness, in terms of end-result variables, is mediated by the core set of intervening variables. These in turn are determined by a complex interaction among leader traits, power, influence and situational variables. Leaders can directly influence intervening variables in a variety of ways, and by taking actions to make the situation more favorable, they can indirectly influence the intervening variables.

The model recognizes the fact that leadership is only one of many determinants of performance, and the possibility that these other influences may overwhelm the leader's influence. The model allows for reciprocal influence processes; leader behavior is both an independent and dependent variable at the same time. Leader behavior is influenced by a variety of factors, including leader attributes, situational demands and constraints, and information about the intervening variables and end results.

In safety leadership, behavior is a function of the leader's traits and skills, altered by the situational

demands and constraints, usually helped by position power. The leader's personal power can add to (or detract from) his/her influence and other factors can enhance or neutralize his/her efforts. Intervening variables are always present to affect results as well.

The Leader's Role

DePree's *Leadership Is an Art* opens with a profound statement: "The first job of the leader is to define reality." Perhaps this is the single most important thing a leader in safety can do. In safety, corporate leaders (CEOs, COOs) historically have not attempted to define reality. Only recently have the tools needed to do this become available.

Following the DePree concept, the process of leadership can be seen as threefold:

- 1) Define reality: Where are we today?
- 2) Define the vision: Where do we want to be?
- 3) Define how we will get there.

Defining Reality

Today, it is possible to define reality in SH&E as never before. Until now, the profession has depended on injury statistics to define the "reality" of safety efforts—a practice that is now roundly questioned. Dependence on audits has been debated in recent years as well. Better upstream measures are now available—based on Deming's philosophies, perception surveys and others metrics—to provide data needed to define reality.

Steps 2 and 3 in the leadership process are discussed by Kotter in "Leading Change: Why Transformation Efforts Fail." Figure 2 depicts his eight-stage process of creating major change.

Safety Excellence & Culture

In the author's opinion, leadership and culture are the two most important subjects to consider with respect to what must be present to achieve safety excellence. Safety policy may or may not be of importance, depending on the worker's perception of whether what management has written (policy) is in fact what happens each day. Management often writes policy, then fails to ensure that it is enforced on the job.

In SH&E, discussion often turns to the "essential elements" of a "safety program." U.S. regulatory agencies such as OSHA provide a guideline as to what those elements are (e.g., policy, training, inspections, investigations). National Safety Council also says certain elements are essential to safety success, only it identifies different elements (Planek and Fearn). Several Canadian provinces state that there are 20 essentials—again, different from the U.S. essentials. Some organizations in the U.K. suggest 30 essential elements (different yet again).

Examination of the rationale behind these different lists reveals that each simply reflects the opinion of the writer (e.g., Heinrich, et al; Bird). Similarly, most regulations on safety programming primarily reflect the opinion of an early writer. Thus, the situation arises where the "essential elements" may work in one organization yet not in another.

When one reviews the research on safety system effectiveness, it becomes clear that there truly are no essential elements for achieving safety results. As noted, the excellent organizations do meet certain criteria, but they clearly do so in very different ways. This poses some serious problems in many countries, as regulations often instruct an organization to have a "safety program" that consists of five (Diekemper and Spartz); seven (Fletcher); or 20 elements (Tye), when many of those prescribed activities may not work and may well waste time, effort and money—resources that could be used to drive proactive activities which will actually prevent loss.

Instead, it is the organization's culture that determines whether or not any single element will be effective. In a positive safety culture, almost any element will work; in a negative culture (one that rewards unsafe behavior), none of the elements are likely to produce results.

If organizational culture is the key, then SH&E management efforts should be aimed first and foremost at building culture so that any safety activities initiated will produce results. Loosely defined, culture is "the way it is around here." Safety culture is positive when the workers honestly believe that safety is a key organizational value—high on the list of priorities.

This perception can only be attained when workers believe management is credible; when the words in the safety policy are lived on a daily basis; when management's financial decisions show that money is spent for people as well as to increase profit; when management-constructed measures and rewards drive mid-manager and supervisory performance; when workers have a role in problem solving and decision making; when a high degree of confidence and trust exists between management and workers; when communication is open; and when workers receive positive recognition.

In such an environment, almost any element of a safety system will be effective. In fact, with the right culture, an organization hardly even needs a "safety program" because safety is addressed as a normal part of the management process.

To achieve a positive safety culture, certain criteria must be met:

- 1) A system must be in place to ensure daily proactive supervisory (or team) activities.
- 2) The system must actively ensure that middle management tasks and activities are conducted in three areas:
 - ensuring subordinate (supervisory or team) regular performance;
 - ensuring the quality of that performance;
 - engaging in certain well-defined activities to show that safety is so important that even upper managers are addressing it.
- 3) Top management must visibly demonstrate that safety has a high value in the organization.
- 4) Any worker who chooses to do so should be able to be actively engaged in meaningful safety-related activities.
- 5) The safety system must be flexible, allowing choices of activities at all levels to obtain ownership.

6) The safety effort must be seen as positive by the workforce.

These six criteria are based on research, benchmarking studies, and observation of world-class systems and step-change improvement organizations [Petersen(d)]. These criteria can be met regardless of the style of management—authoritarian or participative—and they can be met with completely different approaches to safety.

Leadership & Safety

Clearly, leadership is crucial to safety results. Leadership creates and maintains the culture that determines what will—and will not—work in SH&E efforts (or in any other endeavor). An effective leader clearly communicates what results s/he wants—as well as what will be done to achieve those results. Leadership is infinitely more important than policy. Through actions and decisions, a leader sends clear messages to the entire organization regarding which policies are important. SH&E policies often state that safety is a key value, yet measures and reward structures often demonstrate the opposite. Through its actions, systems, measures and rewards, corporate leadership clearly determines whether safety will be achieved in the organization.

This has never been more apparent to workers than in the last decade, during which time the level of stated allegiance to SH&E has grown. At the same time, however, there has never been more rightsizing, more pressure for production and cost reduction, more created stress, more forced overtime, more work for fewer workers, more fear for the future and less security. Rightsizing has decimated middle management (the key person in safety) and supervision. It has put more work on fewer workers. One finds a general perception of overload at all levels, and it is reasonable to surmise that overload causes more accidents, more physical and psychological fatigue, and more stress.

Compounding this is the deterioration of the relationship between the company and the worker—of the once-robust feelings of trust and security. Previously, a worker would continue to “work hurt.” Today, workers fear for their jobs; they see that management ranks are thin and work largely unsupervised. Subsequently, they begin to feel that the organization no longer cares about them. Today, pain means a claim in many companies.

The Leadership Process

The three-step process described earlier is simple:

1) Determine where we are now.

Figure 2

Creating Major Change

1) Establish a Sense of Urgency

- Examine realities.
- Identify and discuss crises, potential crises or major opportunities.

2) Create the Guiding Coalition

- Establish a group with enough power to lead the change.
- Get the group to work together as a team.

3) Develop a Vision & Strategy

- Create a vision to help direct the change effort.
- Develop strategies for achieving that vision.

4) Communicate the Change Vision

- Use every vehicle possible to constantly communicate the new vision and strategies.
- Have the guiding coalition model the behavior expected of employees.

5) Empower Broad-Based Action

- Eliminate obstacles.
- Change systems or structures that undermine the change vision.
- Encourage nontraditional ideas, activities and actions.

6) Generate Short-Term Wins

- Plan for visible improvements in performance or “wins.”
- Create those wins.
- Visibly recognize and reward those who made the wins possible.

7) Consolidate Gains & Produce More Change

- Use increased credibility to change all systems, structures and policies that do not fit together and do not fit the transformation vision.
- Hire, promote and develop people who can implement the change vision.
- Reinvigorate the process with new projects, themes and change agents.

8) Anchor New Approaches in the Culture

- Create better performance through customer- and productivity-oriented behavior; more and better leadership; and more-effective management.
- Articulate the connections between new behaviors and organizational success.
- Develop a means to ensure leadership development and succession.

Source: Kotter(b).

2) Determine where we want to be.

3) Define how we will get there.

Consider again Step 2. What should the organization’s safety system look like? Six criteria were offered earlier against which to assess a safety system. These may be rejected, but to determine where

a company wishes to go, some benchmarks must be used to measure the current state of a safety system.

Another strategy is to consider the climate variable of organizational effectiveness as established by Likert, who showed that the better a company is in certain areas, the more likely it will experience economic success. The author concludes that in SH&E these variables are:

- amount of confidence and trust that exists;
- providing the available required resources;
- manager's general interest in their subordinates;
- information sharing;
- soliciting worker ideas and opinions;
- understanding the worker's problems;
- approachability of top management;
- giving training and helping others;
- recognition for a job well done;
- teaching how to solve problems, rather than merely giving answers.

Other assessment criteria are also available. For example, Zebrowski studied major man-made catastrophes—such as Three Mile Island and Chernobyl—to determine whether any commonality was present in leadership and management styles. He found several negative attributes in common:

- 1) diffuse responsibilities with rigid communication channels and large organizational distances from decision makers to the plant;
- 2) mindset that success is routine with neglect of severe risks that are present;
- 3) rule compliance and the belief that this is enough to ensure safety;
- 4) team player emphasis with no dissent allowed even for evident risk;
- 5) experience from other facilities not processed systematically for application of lessons learned;
- 6) lessons learned disregarded and precautions widely adopted elsewhere neglected;
- 7) safety analysis and responses subordinate to other performance goals in operating priorities;
- 8) emergency procedures, plans, training and regular drills for severe events lacking;
- 9) design and operating features allowed to persist although recognized elsewhere as hazards;
- 10) project and risk management techniques available but not used;
- 11) organization with undefined responsibilities and authorities for recognizing authority, responsibility and accountability.

Where Are You Now?

Several measures of safety performance appear to correlate with the actual accident record in large companies over long periods: behavior sampling (used as a metric); in-depth worker interviews; and perception surveys. In particular, the perception survey can be used to assess the current status of an organization's safety culture. Critical safety issues can be identified and any difference in management and employee views regarding the effectiveness of SH&E programs can be clearly demonstrated. Surveys can also be used to show an organization's propensity for leading its

workers to human error. These types of surveys are measures as well as diagnostic tools.

Much has been learned about what determines the effectiveness of a safety system. Culture is the key. Employee perceptions of that culture dictate their behavior and, thus, the results. Therefore, culture is the determinant of whether or not any element of the SH&E program will be effective. ■

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