Leading in a Crisis: Lessons Learned from 26 Years as a CEO

IHI Forum
Mini-Course M10
December 7, 2015

Blair L. Sadler, JD
Lecturer, Rady School of Management
Past President/CEO
Rady Children’s Hospital, San Diego
Fellow, Hastings Center
Senior Fellow, IHI

Disclosure

• Nothing to Disclose
Learning Objectives

- Managing crises: Lessons Learned from 45 years in health care, including 26 as a hospital CEO
  - Balancing organizational and public interest
  - Providing effective leadership in a crisis

- Learning how to help your organization in preparing for or leading in a crisis
  Developing the courage to act and lead

The Three Victims in any Crisis

- Those directly harmed including immediate families
- Those who work at the organization or are directly connected with it – board members, volunteers
- The organization's overall reputation, including shareholder value
Lessons From Three Crises at Children’s

- 1980 “mystery” virus
- 2001 surgical error
- 2006 child pornography cases

The “Mystery Virus” of 1980

- Three infant deaths
- Act in the public interest - “do no harm”
- Communicate what we knew and didn’t know
- Balance transparency and privacy
- Positive public response – laudatory Union Tribune Editorial
- Winning the Diogynes award for honesty
The Surgical Error of 2001

- The importance of an immediate apology
- Getting to the root cause – a “just culture” vs. a “blame culture”
- Creating our “beyond blame” video story – “unsung heroes”
- Our “promise” to the family
- Repeatedly telling the story to every employee and physician year after year

Lightening Strikes Twice: the Child Pornography Cases of 2006

- A 26 year male employee is accused of trafficking in child pornography, possibly involving our patients
- One month later, a second male employee is accused of a similar crime
- Balancing our needs to protect patient privacy with law enforcement’s needs
When Lightening Strikes (continued)

• Handling the media frenzy while protecting privacy
• Involving all relevant agencies
• Employees feeling betrayed – sharing and acknowledging feelings
• Promise and deliver changes
• The subsequent public response – letters, philanthropy, and awards

Sharing Lessons Learned

The sea change from protectionism to transparency

• With the internet and increasing public expectations, some old rules no longer apply

• Protectionist legal and media advice is usually bad advice

• *Prompt*, appropriate public disclosure and apologies *decrease, not increase*, legal & financial risk

Mars vs. Venus: Two Contrasting Approaches

• 1982 – Johnson & Johnson Tylenol Crisis
  • (prompt, transparent, leader takes charge and assumes responsibility – leadership acts in the public interest)

• 2011 – Pennsylvania State University Abuse Crisis (delay, obfuscation, no one takes charge or assumes responsibility – leadership acts in their own interest)
Lessons Learned: MY Guiding Principles from 40 Years on the Front Lines

• Commit to transparent and consistent internal and external communication
• Provide *prompt* and *proactive* communication
• Balance transparency with privacy of patients, families, and employees
• Share *feelings*: empathy, outrage, sadness, and anger

Lessons Learned (continued)

• Provide visible CEO and senior physician leadership involvement
• Throw away your calendar -- involve all stakeholders around the clock
• Fully collaborate with relevant agencies
• “Own” the problem yourself
• Be cautious of delegating media leadership to an outside firm
Lessons Learned (continued)

• Do the right thing
  • Put mission before margin
  • Act in the public’s interest
• Provide media training
• Have a crisis communications plan
• Provide prompt apologies
• Promise to correct the error and do so
• Share lessons learned

How To Respond…. When There is No Plan

• Form a Crisis Management Team (CMT) led by CEO or other leader” – “Never Worry Alone”
• Notify leadership, board, key stakeholders
• Establish a sense of urgency – 24/7 dedication
• Use checklists to guide you
• Consider enlisting outside help
• Always remember your three priorities
Helping Organizations in a Crisis: A Roadmap

• How can you help organizations effectively manage a crisis?


Leading From Any Chair

• Effective leadership can come from unlikely sources – “from any chair” The Art of Possibility, Zander & Zander

• “Informal” leaders can be the best in certain roles (including a “first victim,” a “second victim,” or a “third victim”
The Barriers to Transparency

1. Organizational Culture – The Three Victims are Upside Down
2. FEAR of legal risk
3. FEAR of reputational harm
4. FEAR of media embarrassment

Its All About the Courage to Act

- Where does courage come from?
- Can it be learned?
- How to develop courage to act
- How to help others develop courage to act.
- The “Looking in the Mirror” Test
Questions?

Contact bsadler@ucsd.edu

Appendix
1. Organizational Culture

The organization, board, and leadership are grounded in the core values of compassion and respect, and the responsibility to always tell the truth.

Harm is seen as the failure of systems and not people, and is considered in a fair and just culture with policies and practices.

2. Insurance Carrier & Legal Counsel

There is a written understanding of how cases will be managed with the insurance carrier and with legal counsel. There is a commitment to rapid disclosure, compensation, and support. Mechanisms are in place for rapid, respectful resolution.
3. Policy, Guidelines & Disclosure

There is a policy on compassionate patient, family and employee communications.
Informed consent policies and practices are up-to-date and effective.
There are policies on disclosure and documentation including procedures for internal and external communications. There is a written crisis management plan.

4. Training

Training programs are in place for staff on communication, expectations, policies, procedures, guidelines.
There is just-in-time coaching (training) for disclosures.
There is media training for key personnel.
5. Disclosure Policy & Processes

The organization is transparent and takes responsibility for its actions.
There is rapid notification of persons harmed and activation of support.
There is a team to support staff in preparing for disclosure.

6. Learning From the Crisis

The organization conducts a thorough objective assessment of the crisis.
Outside advisors are used where appropriate.
The organization is continually learning and improving its practices.
The organization shares lessons learned.