Marshall Memo 378

A Weekly Round-up of Important Ideas and Research in K-12 Education
March 21, 2011

In This Issue:

Quotes of the Week

"It is impossible to live without failing at something, unless you live so cautiously that you might as well not have lived at all."
J.K. Rowling, author (quoted in *Harvard Business Review*, April 2011, p. 103)

"Those who come forward with bad news, questions, concerns, or mistakes should be rewarded rather than shot."
Amy Edmondson (see item #1)

"Avoiding consequential failures means rapidly identifying and correcting small failures… Those that catch, correct, and learn from failure before others do will succeed. Those that wallow in the blame game will not."
Amy Edmondson (*ibid*.)

"When a win is achieved, the organization needs to investigate what led to it with the same rigor and scrutiny it might apply to understanding the causes of failure."
Francesca Gino and Gary Pisano (see item #2)

"If it ain't broke, experiment."
Francesca Gino and Gary Pisano (*ibid*.)

"The right question for leaders of learning organizations to ask is not 'What are we doing well?' but rather 'What experiments are we running?'"
Francesca Gino and Gary Pisano (*ibid*.)

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1. Learning from Failure

"We are programmed at an early age to think that failure is bad," says Harvard Business School professor Amy Edmondson in this thoughtful *Harvard Business Review* article. "That belief prevents organizations from effectively learning from their missteps." The usual reaction to failure is asking people what they did wrong, placing blame, and exhorting everyone to avoid similar mistakes in the future.

But in fact, 95% to 98% of the time, nobody is to blame. Only a small number of failures are due to maliciousness or incompetence; many failures are inevitable and some are actually helpful. Even so, most leaders treat almost all failures as blameworthy. "The unfortunate consequence is that many failures go unreported and their lessons are lost," says Edmondson. There's rarely a culture of psychological safety in which people really learn from mistakes.

A prime reason is that leaders think that if they accept failures and discuss them in an understanding way, they will create a lax work environment in which mistakes happen more frequently. Wrong, says Edmondson: "This common worry should be replaced by a new paradigm – one that recognizes the inevitability of failure in today's complex work organizations. Those that catch, correct, and learn from failure before others do will succeed. Those that wallow in the blame game will not."

The first step in using mistakes productively is understanding why they happened. Edmondson believes there are three kinds of failure:

• *Preventable failures in routine operations* – These usually happen because someone didn't do things the way they are supposed to be done due to inattention, lack of training, or lack of ability. There are two tried-and-true ways to minimize this kind of failure: checklists (as described by Atul Gawande in his best-selling book, *The Checklist Manifesto*; see Marshall Memo 214 for a summary of the main idea), and the andon cord in Toyota factories, which workers pull when they see a defect, immediately setting in motion a diagnostic and problem-solving process.

• *Unavoidable failures in complex systems* – Many organizational failures occur because of the inherent uncertainty involved in operating in challenging environments – for example, a hospital emergency room, responding to enemy actions on the battlefield, operating a nuclear power plant [or working in a school]. To consider failures in such situations bad "is not just a misunderstanding of how complex systems work," says Edmondson. "It is counterproductive. Avoiding consequential failures means rapidly identifying and correcting

small failures. Most accidents in hospitals result from a series of small failures that went unnoticed and unfortunately lined up in just the wrong way."

• *Intelligent failures at the frontier* - Failures in this zone are good because they provide new insights and help the organization improve. "They occur when experimentation is necessary: when answers are not knowable in advance because this exact situation hasn't been encountered before and perhaps never will be again," says Edmondson. Through trial and error on a small scale, the organization avoids making bigger errors on a large scale.

Leadership is essential for an organization to capitalize on failures in the second and third areas. "Only leaders can create and reinforce a culture that counteracts the blame game and makes people feel both comfortable with and responsible for surfacing and learning from failures," says Edmondson. "They should insist that their organizations develop a clear understanding of what happened – not of 'who did it' – when things go wrong. This requires consistently reporting failures small and large; systematically analyzing them; and proactively searching for opportunities to experiment."

Here are the key leadership steps for creating an environment in which it's psychologically safe for subordinates to report failures:

- Frame the work accurately. Is it routine, complex, or innovative? The head of a research and development company might tell subordinates, "We're in the discovery business, and the faster we fail, the faster we'll succeed."
- Embrace messengers. "Those who come forward with bad news, questions, concerns, or mistakes should be rewarded rather than shot," says Edmondson. "Celebrate the value of the news first and then figure out how to fix the failure and learn from it."
- Be humble. It's helpful when bosses are open about what they don't know, mistakes they've made, and the fact that they can't manage everything alone.
- Invite participation. Ask for input and create opportunities for people to find and analyze failures and suggest intelligent experiments.
- Set boundaries and hold people accountable. "Paradoxically, people feel psychologically safer when leaders are clear about what acts are blameworthy," says Edmondson. "And there must be consequences. But if someone is punished or fired, tell those directly and indirectly affected what happened and why it warranted blame."

The key, she continues, is detecting failure, analyzing it, and experimenting.

• *Detecting failure* – The problem is that subordinates who spot problems are often afraid of being "the skunk at the garden party" – and many bosses shoot the messenger. The boss needs to encourage open discussion, welcome questions, and display humility and curiosity. When Alan Mulally took over Ford Motor Company in 2006, he asked managers to color code their reports: green for good, yellow for caution, and red for problems. At his first leadership meeting, all the reports were green. Mulally told the group that the company had lost several billion dollars the year before and asked, "Isn't anything *not* going well?" A manager timorously changed his report to yellow because a serious product defect was going to delay the launch. After a deafening silence, Mulally applauded. From then on, meetings were full of color and Ford has had the strongest record of any American car company.

It's also important to admit when an experiment has failed and needs to be scrapped. "The human tendency to hope for the best and try to avoid failure at all costs gets in the way," says Edmondson, "and organizational hierarchies exacerbate it… We throw good money after bad, praying that we'll pull a rabbit out of a hat."

• *Analyzing failure* – "Left to our own devices, most of us will speed through or avoid failure analysis altogether," she says. A common reason is the fundamental attribution error – the tendency to blame external factors or bad luck when *we* mess up, but hold others responsible when *they* fail. "The job of leaders is to see that their organizations don't just move on after a failure but stop to dig in and discover the wisdom contained in it," she continues. It's emotionally unpleasant work and reduces self-esteem, which is why it's so important to establish the right culture. After the Columbia space shuttle disintegrated as it reentered the earth's atmosphere, a failure analysis identified the first-order cause – a piece of foam from the external fuel tank had hit the shuttle's wing during the launch – and also the second-order causes – NASA's rigid, schedule-obsessed culture that made it impossible for engineers who knew about the problem to speak up in time to avert the accident.

• *Promoting experimentation* – What this means is strategically producing failures in the right places and at the right times and immediately learning from them. In basic scientific research, the failure rate for experiments is 70 percent or more. "How do these people get out of bed in the morning?" asks Edmondson. "First, they know that failure is not optional in their work; it's part of being at the leading edge of scientific discovery. Second, far more than most of us, they understand that every failure conveys valuable information, and they're eager to get it before the competition does."

Another key to successful experimentation is not conducting trials in ideal, greenhouse conditions. Only when they are done in a real-world environment will they yield mistakes and insights that lead to intelligent corrections.

"Strategies for Learning from Failure" by Amy Edmondson in *Harvard Business Review*, April 2011 (Vol. 89, #4, p. 48-55), no e-link available

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2. Learning from Success

"Ironically, casting a crucial eye on your success can better prepare you to avoid failure," say Harvard Business School professors Francesca Gino and Gary Pisano in this intriguing *Harvard Business Review* article. However, few leaders do this because of three common impediments:

- The fundamental attribution error – When we succeed, we tend to credit our talents and our current strategy and downplay the role of environmental factors and luck.
- Overconfidence bias – Success breeds self-assurance, which can make us believe that nothing needs to be changed.
- The failure-to-ask-why syndrome – There's a tendency not to systematically investigate the causes of good performance, avoiding tough questions that would help expand our knowledge or alter assumptions about how the world works.

Gino and Pisano suggest five ways to counteract these tendencies:

• *Celebrate success, but examine it*. "There is nothing wrong with toasting your success," they say. "But if you stop with the clinking of the champagne glasses, you have missed a huge opportunity. When a win is achieved, the organization needs to investigate what led to it with the same rigor and scrutiny it might apply to understanding the causes of failure." It's possible that success happened because of blind luck, or because of factors that are impossible to replicate.

• *Systematically review projects*. The U.S. military conducts "after-action reviews" after each combat encounter and training exercise, whether it was successful or not. *What did we set out to do? What actually happened? Why did it happen? What are we going to do next time?* These debriefs produce insights that can be put to work immediately. Pixar has produced eleven highly successful animated films in a row – yet after each one, it conducts a thorough analysis, asking what five things should be done again and what five things should be stopped. [See Marshall Memo 248 for more on this.] "The challenge, of course, is to apply the same degree of rigor whether things are going well or badly," say Gino and Pisano. "We all tend to spend much more time reviewing the performance of the employee who is struggling than of the one who is cruising along. However, understanding the reasons behind the good performance of successful employees may bring to light important lessons for others."

• *Use the right time horizons*. In some cases, the time-lag from action to consequences is short, and it's easy to draw conclusions. But in other cases, results aren't evident for months or years. "Unless you have the appropriate time frame for evaluating performance, you are likely to misconstrue the factors that led to success or failure," say Gino and Pisano. It's important not to be "fooled by randomness."

• *Recognize that replication is not learning*. There's a tendency to replicate the factors involved in success. "But if the chief lesson from a successful project is a list of things to do the same way the next time, consider the exercise a failure," say Gino and Pisano. Rather, we should dig into root causes of success, separating factors under our control from those that aren't and how they interact.

• *If it ain't broke, experiment*. Experimentation is the way to test assumptions and theories about what's needed to achieve high levels of performance, say Gino and Pisano. "And it should continue even after success… Engineers routinely subject their designs to ever-more-rigorous tests until the thing they are designing actually breaks… The right question for leaders of learning organizations to ask is not 'What are we doing well?' but rather 'What experiments are we running?'"

"Why Leaders Don't Learn from Success" by Francesca Gino and Gary Pisano in *Harvard Business Review*, April 2011 (Vol. 89, #4, p. 68-74), no e-link available; the authors can be reached at fgino@hbs.edu and gpisano@hbs.edu.

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3. Being Aware of Ethical Blind Spots

"Good people often let bad things happen," say Harvard Business School professor Max Bazerman and Notre Dame professor Ann Tenbrunsel in this *Harvard Business Review* article. Why? Because cognitive biases and organizational systems blind them to unethical behavior. Here's their list, with a suggested remedy for each one. Ask yourself if any of these might apply in K-12 education:

• *Ill-conceived goals* – Targets and incentives that are set to promote a desired behavior can unwittingly encourage a negative one. For example, in the 1990s, Sears, Roebuck gave automotive mechanics a sales goal of $147 an hour to encourage them to work faster. What happened was that mechanics overcharged for their services and "repaired" things that weren't broken. Remedy: "Leaders setting goals should take the perspective of those whose behavior they are trying to influence and think through their potential responses," say Bazerman and Tenbrunsel. Brainstorm unintended consequences and consider alternative goals that may be more important to reward.

• *Motivated blindness* – Managers see what they want to see and overlook unethical behavior in others when they have a vested interest in remaining ignorant. For example, in the 1970s, engineers working on the Pinto at Ford Motor Company discovered just before production was about to begin that when the car was involved in a rear-end collision, it could leak gasoline and explode. Managers did a cost-benefit analysis and decided that redesigning the car and delaying production would be more costly than potential injuries and lawsuits. Top Ford executives "not only seemed unable to clearly see the ethical dimensions of their own decision but failed to recognize the unethical behavior of the subordinates who implemented it," say Bazerman and Tenbrunsel. Remedy: Root out conflicts of interest. Simply being aware of conflicts is not enough to eliminate their impact on decision-making.

• *Indirect blindness* – There's a tendency to hold others less accountable when unethical behavior is carried out by third parties. For example, a pharmaceutical company sells the rights to a cancer drug to another company, which then raises the price 1,000%. Remedy: When handing off an enterprise to a third party, ask whether the assignment might invite unethical behavior and if so, take responsibility.

• *The slippery slope* – Research shows that people are less able to see unethical behavior when it develops gradually, one small indiscretion at a time. A frog will jump out of a pot of boiling water, but if the water is cold to start and slowly warmed to a boil, the frog won't jump out and will be cooked to death. Remedy: Be alert for even trivial infractions and address them immediately.

• *Overvaluing outcomes* – People tend to give a pass to unethical behavior if the outcome is good. For example, a scientist developing a drug is under time pressure and makes up data on four subjects, producing a favorable result by the deadline. The drug goes on sale, helps sick people, and is profitable. When asked to evaluate the ethics of this situation, versus a similar one in which the drug went on the market and resulted in four deaths, people tend to be more forgiving of the first than the second. Remedy: Examine both "good" and "bad" decisions for their ethnical implications and reward solid processes, not just good outcomes.

"Ethical Breakdowns" by Max Bazerman and Ann Tenbrunsel in *Harvard Business Review*, April 2011 (Vol. 89, #4, p. 58-65), no e-link available

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4. A Model for Transformational Change

In this inspiring article in *The School Administrator*, authors Chip and Dan Heath describe how physician Donald Berwick went about saving more than 100,000 lives. Berwick and his colleagues at the Institute for Healthcare Improvement knew what all medical practitioners know – that the "defect" rate in most hospitals is as high as 10 percent. For example, about 10 percent of patients don't get their antibiotics at the right time and in the right dosage. Because of errors like these, tens of thousands of patients die each year.

Berwick had studied Total Quality Management in corporations and wondered why the methods that have reduced errors to 1 in 1,000 at Toyota plants couldn't be applied to health care. He identified areas of patient care where specific procedures had been shown to reduce the error rate to zero – for example, elevating the heads of patients in ventilators 30-45 degrees prevents oral secretions from getting into the windpipe.

On December 14, 2004, Berwick gave a speech at a large industry convention and challenged an audience of hospital administrators to save some of their patients' lives soon. "Some is not a number," he continued. "Soon is not a time. Here's the number: 100,000. Here's the time: June 14, 2006 – 9:00 a.m." – exactly 18 months away.

Berwick then introduced the mother of a girl who had died because of a medical error. "I'm a little speechless," she said, "and I'm a little sad, because I know that if this campaign had been in place four or five years ago, that my daughter Josie would be fine… But, I'm happy, I'm thrilled to be part of this, because I know you can do it."

Berwick made it easy to sign up for the program, and more than 1,000 hospitals quickly did so. The Institute for Healthcare Improvement gave hospital staffs step-by-step training and manuals on six specific procedures. They held conference calls in which hospital leaders shared ideas. Some doctors were irritated by the new procedures, saying they were overly constricting, but as the months went by, hospitals began to see dramatic improvements in infection rates and mortality. The word spread and more hospitals joined the campaign.

Exactly 18 months after his initial speech, at 9:00 a.m. on June 14, 2006, Berwick announced the results. The hospitals in the campaign had collectively prevented 122,300 deaths and had put in place procedures that would continue to save lives and improve health-care outcomes into the future.

How was Berwick able to get hospitals to change entrenched procedures when he had no positional power and only a small staff? The Heaths attribute this dramatic success to the following factors:

- Setting a crystal-clear goal and timeline – 100,000 lives saved in 18 months;
- Putting a human face on medical errors by having the mother speak, engaging the hospital leaders' emotions;

- Proposing six proven methods for accomplishing the goal (versus talking about "evidence-based medicine" or "bringing Total Quality Management to health care");
- Maintaining a laser-like focus on the faithful implementation of the six procedures;
- Shaping the pathway to success: making it easy to enroll, providing training, and getting hospitals talking to and supporting each other.

The Heaths use the metaphor of a Rider trying to guide an Elephant down a Path to explain how change happens. We have to appeal to the Rider (people's intellectual side) and the Elephant (people's emotions), and we need to show a Path to success.

The Heaths believe this applies to education as well as medicine. They tell the story of Molly Howard, who in 1995 became principal of a 3,000-student high school in rural Georgia where only 15 percent of students typically went on to postsecondary education and many teachers had the attitude that "some children *can* and some children *can't*." Howard quickly made several changes:

- She abolished a two-track system that had separated "college-bound" from "vocational" students;
- She matched students with on-campus advisors who stayed with them all four years of high school;
- She beefed up assessments and tutorial programs;
- She changed the A-B-C-D-F grading system to A-B-C-NY (Not Yet);
- She had teachers explain to students exactly what A, B, and C work looked like.

The school made dramatic progress in achievement, graduation rates, and climate. In 2008, Howard was selected as national Principal of the Year by NASSP. She's now superintendent of the district's schools.

"The changes you face may feel daunting," conclude the Heaths, "but there is tremendous hope in change stories like those of Donald Berwick and Molly Howard. Both walked into situations where bad behaviors were so entrenched that no one was trying to change. Yet both of them systematically addressed the weaknesses of Rider and Elephant. And they both succeeded where no one thought success was possible."

"Overcoming Resistance to Change" by Chip Heath and Dan Heath in *The School Administrator*, March 2011 (Vol. 68, #3, p. 28-32), no e-link available. Chip Heath can be reached at chip.heath@stanford.edu. The article is based on the Heaths' book, *Switch: How to Change Things When Change is Hard* (Broadway, 2010).

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5. Teaching High-School Students to Read Challenging Material

In this *Education Week* article, Catherine Gewertz reports on work being done in 18 New York City high schools to gauge the difficulty level of reading material and give their students the tools to unpack and understand dense, challenging content-area texts. The goal is to help students climb beyond the plateau of mediocre reading skills at which many are stuck and develop the reading and writing proficiencies they will need to succeed in college –

especially the ability to dissect information from complex texts and build evidence-based arguments.

Gewertz describes one meeting in which teachers discussed whether *Huckleberry Finn* was more appropriate for high school or college, analyzing it on five dimensions:

- How daunting is the text on the page?
- How easy and natural is the language?
- How circuitous is the plot?
- Does it have multiple, elusive layers of meaning?
- What prior knowledge is required to understand it?

Teachers flatly disagreed on whether the novel should be taught to their students or held until college.

The group then listened to reading experts Timothy and Cynthia Shanahan on what's demanded of high-school students in different subject areas:

• English – Students usually read a story or chapter all the way through and then go back to analyze and discuss themes and structure.

• Mathematics – Students need to read and re-read a few lines of text – "close reading" – to extract the precise meaning.

• History – Students need to make connections among events, evaluate information from multiple sources, and discern the author's point of view.

• Science – Students need to absorb information from diagrams and formulas as well as from the prose.

In addition, each subject has its own vocabulary and "grammar." For example, in math, A + B is equal to B + A, but in science, H_20 is not the same as OH_2.

Timothy Shanahan says that expecting 14-year-olds to grasp high-level material in different subjects is like dropping them off unaccompanied in different countries and expecting them to manage. "That's what we do every day in schools," he says. "We move them from the land of math to science to history with no guides."

The teaching challenge is helping students climb the "staircase" of increasingly complex texts in each subject. "You can't build knowledge without reading sufficiently rich and complex text," says David Coleman, who worked on the Common Core State Standards. Teachers also need to resist the tendency to oversimplify texts. "Too often," says University of Michigan professor Mary Schleppegrell, "teachers simplify rather than dive deeply into it. On the secondary level, you can't really make it simpler and still maintain the level of content. You have to amplify instruction around it."

Measuring the difficulty level of texts is important for teachers, and the New York City group looked at the three-part model suggested in the Common Core Standards:

- The quantitative dimension – Word length, sentence length, and text cohesion as measured by computerized readability formulas;
- The qualitative dimension – Purpose, levels of meaning, structure, language conventions, clarity, and knowledge demands, which can be ascertained only by an attentive human reader;

- The reader and task dimension – The motivation, knowledge, and experiences students need to read a text successfully – best determined by teachers who know their students and subject well.

Pegging the difficulty level of texts helps teachers to figure out how to escort their students to higher levels of comprehension, which gives them access to content knowledge contained in the material. This realization has helped enlist math, science, and history teachers in their schools' literacy effort.

In one New York City school, science teachers had students read an article from a science journal aloud and mark the parts they found easy and difficult and then looked at how they tackled Regents test questions. Students could read aloud quite fluently but there were gaps in their comprehension – especially with acronyms and appositives. That helped teachers formulate strategies for upcoming lessons.

Background knowledge is especially important for high-school students. "Teachers are going to have to pay attention to developing the underpinning concepts that kids need to read well and get engaged in informational text," says Barbara Kapinus of the National Education Association. "Where we brushed science and social studies aside in the early grades to focus on math and reading, we can no longer afford to do that. That's a change in the whole focus of schooling."

"Teachers Seek Ways to Gauge Rigor of Texts" by Catherine Gewertz in *Education Week*, Mar. 16, 2011 (Vol. 30, #24, p. 1, 12-13), http://edweek.org

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6. David Brooks on Incentive Pay and Other Phenomena

In this *New York Times* column, David Brooks cites several pieces of social-science research bearing on the invisible ties that influence human behavior:

• *Individual versus group incentives* – The conventional wisdom is that people will work harder if they are paid more individually – but that's not true. "A large body of research suggests it's better to motivate groups, not individuals," says Brooks. "Organize your people into a group; reward everyone when the group achieves its goals." A recent paper by Susan Helper, Morris Kleiner, and Yingchun Wang compared compensation schemes in the manufacturing sector and found that group incentive pay is more effective at motivating workers than individual merit pay.

• *Hurting the one we love* – People are more likely to break promises to loved ones, according to research by Johanna Peetz and Lara Kammrath. That's because affection leads them to make lavish promises that they really mean but may be unable to keep.

• *Relay race performance* – Swimmers outperform their individual times in the final laps of Olympic relay races, according to research by Joachim Huffmeier and Guido Hertel. "In the heat of a competition, it seems, later swimmers feel indispensible to their team's success and are more motivated than when swimming just for themselves," says Brooks.

• *The home-team advantage* – Surprisingly, athletes don't perform any better with the home crowd cheering them on, as measured by free-throw percentages and pitchers' strike-to-

ball ratios, according to a *Sports Illustrated* article by Tobias Moskowitz and Jon Wertheim. Nor is fatigue from travel a factor; when playing in a rival stadium, teams from the same metropolitan area lose at the same rate as teams from across the country. The real difference is the umpires. They don't like being booed and call more strikes and more fouls on away players with the home fans breathing down their necks. The louder and closer the crowd is, the more referees favor the home team. "It's not a conscious decision," says Brooks. "They just naturally conform a bit to the emotional vibes radiating from those around them."

"Social Science Palooza II" by David Brooks in *The New York Times*, Mar. 18, 2011,
http://www.nytimes.com/2011/03/18/opinion/18brooks.html?_r=1&scp=1&sq=%22Social%20Science%20Palooza%22&st=cse

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Do you have feedback? Is anything missing?

If you have comments or suggestions, if you saw an article or web item in the last week that you think should have been summarized, or if you would like to suggest additional publications that should be covered by the Marshall Memo, please e-mail: kim.marshall8@verizon.net

About the Marshall Memo

Mission and focus:

This weekly memo is designed to keep principals, teachers, superintendents, and others very well-informed on current research and effective practices in K-12 education. Kim Marshall, drawing on 41 years' experience as a teacher, principal, central office administrator, and writer, lightens the load of busy educators by serving as their "designated reader."

To produce the Marshall Memo, Kim subscribes to 44 carefully-chosen publications (see list to the right), sifts through more than a hundred articles each week, and selects 5-10 that have the greatest potential to improve teaching, leadership, and learning. He then writes a brief summary of each article, pulls out several striking quotes, provides e-links to full articles when available, and e-mails the Memo to subscribers every Monday evening (with occasional breaks; there are about 50 issues a year).

Subscriptions:

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Publications covered

Those read this week are underlined.

American Educator
American Journal of Education
American School Board Journal
ASCD, CEC SmartBriefs, Daily EdNews
Ed. Magazine
EDge
Education Digest
Education Gadfly
Education Next
Education Week
Educational Leadership
Educational Researcher
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Essential Teacher (TESOL)
Harvard Business Review
Harvard Education Letter
Harvard Educational Review
JESPAR
Journal of Staff Development
Language Learner (NABE)
Middle Ground
Middle School Journal
New York Times
Newsweek
PEN Weekly NewsBlast
Phi Delta Kappan
Principal
Principal Leadership
Principal's Research Review
Reading Research Quarterly
Reading Today
Rethinking Schools
Review of Educational Research
Teachers College Record
The Atlantic Monthly
The Chronicle of Higher Education
The Language Educator
The Learning Principal
The New Yorker
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The School Administrator
Theory Into Practice
Tools for Schools