

Preview:

Lean Practice Guide: Psychological Safety for Lean Leaders

Make It Safe to Speak Up, So Improvement Can Actually Happen

OR

The Silence Tax: A Lean Leader's Guide to Making It Safe to Speak Up

OR

The Cord Nobody Pulled: Why Good Tools Don't Fix Broken Cultures (or: What It Takes to Make Improvement Actually Stick)

Mark Graban

Copyright (c) 2026 Mark Graban & Constancy, Inc.

Published by Constancy, Inc.

MarkGraban.com

All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means without the prior written permission of the

publisher, except in the case of brief quotations in reviews and certain other noncommercial uses permitted by copyright law.

Updated in-progress edition: April 22, 2026

Dedication placeholder

A Note to Early Readers

Thank you for purchasing this book while it's still being written.

You're reading an in-progress edition. The remaining chapters are outlined and will be added as they're finished. As a Leanpub reader, you'll receive every update automatically—including the final, complete book.

If something resonates, or if something doesn't, I'd genuinely like to hear from you. You can reach me at mark@markgraban.com or connect with me at markgraban.com.

I appreciate your willingness to come along early. I hope you'll write back and tell me what lands and what doesn't.

— Mark Graban

Introduction

Much of the case for psychological safety has been made with anecdotes. My own included. For years, I've told stories about Toyota plants where the andon cord gets pulled thousands of times a week and Ford plants where the same cord gathers dust. About hospital units where nurses flag near-misses and ones where they don't. About huddle boards that surface problems and huddle boards that have become corporate wallpaper. The argument was always: these stories point to something real, something about how the culture around the tools determines whether the tools do anything.

In 2025, four researchers ran the numbers on it.

Nguyen Ngoc Anh, Thoa Xuan Thi Pham, Anh Chi Phan, and Yoshiki Matsui pulled data on 330 manufacturing plants across 15 countries and three industries—electronics and electrical, machinery, and transportation components. The data came from the High-Performance Manufacturing Project, an international research consortium that has been tracking operational data for decades. Not a survey of knowledge workers. Not a tech company study. Three hundred and thirty factories.¹

What they found was not subtle. On a zero-to-one scale, the relationship between psychological safety and improvement capability scored 0.73. Strong. When they separated improvement capability into two parts—maintenance (following existing procedures) and improvement (the kaizen part: speaking up, suggesting changes, experimenting)—the effect on the improvement dimension jumped to 0.87. The f-squared value was 0.50, a large effect size by any standard in this kind of research.

Psychological safety doesn't just help people follow the standard. It drives the behavior that Lean depends on.

The same paper references commonly reported failure rates for continuous improvement initiatives: around 70 percent for implementation, and 66 to 90 percent for sustaining those efforts over time.² Different studies define "failure" differently. Call it seven in ten. Call it two in three. The precise number doesn't change the shape of the problem.

If you're a Lean leader reading this, you already know the shape. Programs get launched. Training gets delivered. A few projects succeed. Energy builds. And then, somewhere between eighteen months and three years in, the momentum leaks out. The tools are

¹ Nguyen Ngoc Anh, Thoa Xuan Thi Pham, Anh Chi Phan, and Yoshiki Matsui, "The Impact of Psychological Safety on Improvement Capability: The Moderating Role of Manufacturing Complexity," *Operations Management Research* 18, no. 1 (2025): 400-421.

² Commonly cited failure rates for continuous improvement initiatives are discussed in Nguyen et al., "The Impact of Psychological Safety on Improvement Capability," 402. The implementation figure (around 70 percent) draws on Mark Hughes, "Do 70 Per Cent of All Organizational Change Initiatives Really Fail?," *Journal of Change Management* 11, no. 4 (2011): 451-464; and Carlos J. E. Candido and Sergio P. Santos, "Strategy Implementation: What Is the Failure Rate?," *Journal of Management and Organization* 21, no. 2 (2015): 237-262. The sustainment figure (66 to 90 percent) draws on Daniel B. Henrique et al., "A New Value Stream Mapping Approach for Healthcare Environments," *Production Planning and Control* 32, no. 15 (2021): 1237-1254. Hughes examines the "70 percent" claim critically rather than simply confirming it; the number is best understood as a commonly cited range with varying definitions of "failure" across studies.

still on the wall. The binders are still on the shelf. The huddle boards are still there. But the behavior has quietly reverted.

When I ask leaders what went wrong, I hear a lot of answers. We didn't pick the right projects. We didn't have executive support. We didn't sustain it through the reorg. The transformational CEO left. Every one of those is real, and in any given stalled transformation, several of them are probably true.

What do they have in common? They're all things somebody could have seen coming. The wrong project was wrong in week two, not after a year of work—an operator on the line could have told you. The executive sponsor's commitment was performative from the start—the director two levels down could smell it. The CI team's budget had been on the chopping block for six months before the cut—finance had been saying so quietly.

In each case the information existed inside the organization before the post-mortem found it. Somebody knew. The post-mortems don't spend much time on why nobody said anything, probably because the people who went quiet don't tend to show up for the post-mortem. What gets captured is the version of events reconstructed from the people still in the room.

A Lean system without people speaking up is a set of tools no one is using.

That missing variable is what this book is about. I've come to call it the silence tax—the cost an organization pays, continuously and mostly invisibly, when the people closest to the work decide speaking up isn't worth the trouble, or never believed it was. The tax shows up in problems that travel further than they should before anyone catches them. In experienced people who quietly stopped contributing without anyone noticing when. In mistakes that repeat because the first version was never reported. By its nature the tax shows up as silence—what you don't hear, what nobody brings up anymore, the meeting where everyone nods. You can walk a plant or a hospital and not see what isn't there.

This book is about what that tax is costing you, and how to stop paying it.

Why This Book Exists

A lot of what's in this book is intuitive to me from thirty years of studying and practicing Lean. Respect for people. Blame the process, not the person. Go see. Ask why. Make it safe to surface problems. I was taught those things by good Lean teachers long before I ever read the words "psychological safety." When I finally did encounter Amy Edmondson's work, it didn't feel like a new idea so much as a precise name for something Lean had always been pointing at. I wish I'd had the language sooner. More

than that, I wish I'd had the specific, research-backed recommendations on how to build it.

In *Lean Hospitals*, first published in 2008, I wrote:

"We must create a safe environment where staff can speak up and make problems visible rather than being pressured into hiding or ignoring them."

That sentence is doing the work of "psychological safety" without naming it. I had the idea. I didn't have the vocabulary, and I didn't have the how-to. This book tries to add both.

After publishing *The Mistakes That Make Us*, I kept having a version of the same conversation with leaders at keynotes and client sites. They'd nod along with the case for learning from mistakes, and then they'd ask some version of: "So what do I actually do on Monday?" That book was written for a broad audience and stays close to one thing—learning from mistakes and preventing them. This book is wider and more specific at the same time. Wider because psychological safety isn't only about mistakes; it's also about the harder everyday dynamics like disagreeing with your boss or flagging a timeline that won't hold. More specific because it's written by a Lean person for Lean people, and the recommendations connect directly to the tools and systems you already know.

The Idea Was Already Here

Lean leaders sometimes feel defensive about psychological safety because it sounds like something the HR function invented recently and bolted on to operational work. It isn't. The idea was in the Lean and quality tradition long before the business world had a name for it.

Start with W. Edwards Deming. His eighth point for management, published in *Out of the Crisis* in 1986, was "drive out fear, so that everyone may work effectively for the company."³ What gets less attention is what Deming thought should replace fear. He didn't want it replaced with enthusiasm, or slogans, or a suggestion program. He wanted it replaced with leadership—the kind where a manager's job is to help people do better work, not to catch them doing something wrong. Fear out, leadership in. The rest of the fourteen points elaborate what that leadership looks like in practice.

³ W. Edwards Deming, *Out of the Crisis* (Cambridge, MA: MIT Press, 1986), 23-24.

Dr. Don Berwick was a direct student of Deming. In 1989, Berwick published an editorial in the *New England Journal of Medicine* that, re-read today, sounds like it could have come out last week. He argued that leaders had to take the lead in continuous quality improvement, "replacing blame and finger pointing with shared goals." He criticized disciplinarian leaders who went looking for "bad apples" to punish instead of improving processes. He wrote that a leader could not be a mere observer of problems. He cited an epigram he had picked up:

*"Every defect is a treasure. In the discovery of imperfection lies the chance for processes to improve."*⁴

Amy Edmondson's first peer-reviewed research on psychological safety came out five years later, in the mid-1990s. Berwick wasn't using her vocabulary. He was describing the conditions under which people would tell the truth about problems—and warning that if leaders kept blaming individuals, those conditions would never exist. Read his editorial today and the overlap with Edmondson's later work is striking. He just didn't have the label.

For healthcare leaders who think of psychological safety as imported jargon: the idea has been in their professional tradition for more than thirty-five years. And the thing Berwick was describing is not soft. He was writing in a clinical research journal, about patient outcomes, about leaders who could either do this work or fail to do it. That's the register this book wants to operate in.

A Note on National Cultures

A 2017 meta-analysis by Frazier and colleagues pulled together 136 studies covering more than 22,000 individuals and nearly 5,000 groups, and found that the relationship between psychological safety and performance held across national cultures. North America, Europe, Asia—the same pattern.

I hear a common objection on this point from Lean leaders. It's that andon culture is a Japanese thing—deference to hierarchy, consensus-building, long workforce tenure, shared language. On that view, the workforce does the work. Toyota's management system just gives them something to pull.

⁴ Donald M. Berwick, "Continuous Improvement as an Ideal in Health Care," *New England Journal of Medicine* 320, no. 1 (1989): 53-56.

Toyota runs andon-pulling plants in locations including Japan, Kentucky, Baja California, and Ontario. Same cord. Same usage pattern. Different workforces. Same management system.

What This Book Is and Isn't

This is a practical companion to my earlier book, *The Mistakes That Make Us*. That one makes the case through stories, across a wider audience of leaders who may or may not come from a Lean background. It's the deeper treatment of mistakes specifically, and the book I'd hand to a non-Lean leader who wants to understand why punishing mistakes backfires. You don't need to read it before this one. There isn't a lot of overlap. If you've already read it, a few familiar threads will surface, but this book is its own thing—written from a Lean person to Lean people, and broader in scope than mistakes alone.

It's not an academic treatment of psychological safety. Edmondson's *The Fearless Organization* and Clark's *The 4 Stages of Psychological Safety* already exist and are both worth your time. I cite them throughout. This book is also not a comprehensive tour of Lean. I'm going to assume you already know what an andon cord is, what PDSA stands for, and roughly what a huddle board looks like on a good day.

Nine chapters. The first three describe the problem—why the training didn't stick, what psychological safety actually is, and why people go quiet and stay quiet. The next three describe what to do: model it, encourage it, reward it. The last two deal with measurement and with the question of what to do this week. Read it straight through, ideally. Different readers will use it different ways—solo, with a team, as a self-assessment, skipping ahead to the practical chapters. All of that is fine. The book was built to work that way.

One finding from the Nguyen study runs through the whole book. In highly complex manufacturing environments, psychological safety alone wasn't enough to drive improvement. Teams needed psychological safety plus structural support—tools, systems, training, a way to turn speaking up into solving. That finding, if it holds up in replication, is the whole argument of this book in a sentence. The tools don't work without the culture. The culture doesn't produce results without the tools. A lot of Lean programs have one. Not many have both. The silence tax gets paid in both cases.

If your transformation is stalling, the question I'd ask first isn't whether you picked the right A3 project. It's whether the people closest to the work feel safe telling you what's actually going on.

I hope the book helps you see what's working on your team and what isn't. And whether, when they do, anything happens next.

Chapter 1: The Problem You've Already Tried to Solve

"You've gotta beat down on them, beat down on them, beat down on them, until they do exactly what they're told."

That was the management philosophy of my plant superintendent at a General Motors engine factory in Michigan, explained to me one day in plain terms. Thick Chicago accent. Bad toupée. Not a trace of a smile. Bob wasn't a guy who joked around—he pounded his closed fist into his open hand on each "beat down." He said it three times. I can still hear him. Sadly, he actually managed that way.

A few months later, with no apparent sense of irony, Bob complained:

"Nobody around here takes any initiative."

To this day, I believe Bob thought those were two separate problems.

Sadly, Bob couldn't see it. He had built a system that trained every person in that plant to keep their mouths shut about problems and their observations to themselves. And then he blamed them for doing exactly what his system had taught them to do.

Bob was the loud version of the problem. Most of what keeps people quiet isn't nearly this dramatic. It's corporate, polite, and usually sitting in plain sight.

I needed to get an MRI a while back. In the lobby, there was a big sign. It was professionally made. Somebody had paid for it. It read, in part:

"We are a culture of continuous innovation and continuous improvement."

I read it twice. I still wasn't sure what it was telling me. Was this information for patients? Was I supposed to do something with it? I asked the woman at the front desk about it. She rolled her eyes at me with a sly smile. She said she had no idea what it was about.

That's the version of the problem most organizations actually have. Nobody's being beaten down. There is, however, a sign on the wall. There's probably been real money spent on problem-solving training—A3 thinking, root cause analysis, PDSA cycles, maybe kata coaching. The training was technically correct. The facilitators knew their stuff. It works fine in the classroom. But people go back to the floor, the clinic, or the office, and the problems don't surface. The suggestion box collects dust. The huddle board becomes wallpaper. The gemba walk produces polite nods and "everything's fine."

And it's not just frontline workers. It's the CIO who disagrees with the CEO's strategy but won't say so in the boardroom. It's a middle manager who sees problems with a project plan but keeps quiet because the last person who pushed back got frozen out. The silence often runs all the way up.

People might very well know how to solve problems. They don't feel safe raising them. Or it's just not worth the effort.

Same Cord, Different Culture

One of the clearest illustrations of this gap comes from another legacy Detroit automaker. In 2007, a BBC reporter visited two assembly plants and compared a single tool: the andon cord. It's a cord—or sometimes it's buttons—that any worker on the assembly line can pull to signal a problem. At Toyota's plant in Georgetown, Kentucky, that cord gets pulled thousands of times a week.⁵

When I've visited Toyota plants in Kentucky, Texas, and Japan, it's true—the andon cords are being pulled frequently enough that you almost always hear the singsong chimes they produce. Songs such as "Mary Had a Little Lamb" tell team leaders that their assistance is needed right away. You hear the chimes, and you see people responding—not in a panic, but with a purpose. The audible evidence is apparent, if not annoying.

⁵ Steve Schifferes, "The Triumph of Lean Production," BBC News, February 27, 2007, <http://news.bbc.co.uk/2/hi/business/6346315.stm>.

Back to that article. At a Ford truck plant, the cord got pulled only twice a week. It's quite possible that a maintenance worker on first shift was tasked with testing the system weekly, just like a colleague on second shift. (Note: This was reported at the time of the BBC visit; I'm still researching whether it reflects Ford's current practice and culture.)

Same tool. Same cord. Completely different results.

Fear explains part of it. Workers weren't sure it was safe to raise problems. They probably knew, from experience, that it wasn't. And even when they did, the system wasn't set up to respond. Even a worker with no fear will stop pulling the cord if nothing useful happens when they do.

The contrast gets sharper when you look at NUMMI, the GM-Toyota joint venture in Fremont, California. NUMMI reopened in 1984 with basically the same UAW workforce GM had written off as unmanageable—a plant once infamous for absenteeism, sabotage, grievances, and rework. Toyota installed the andon cord, put team leaders in place, and told workers they were expected to use it.

Almost nobody did at first. The cord had reportedly been pulled only a handful of times in the first month. These were the very workers GM had given up on. They'd spent years learning that raising problems got you nothing good. A cord hanging down doesn't undo that. You can install the system in a weekend. You can't just install the trust.

About a month after the plant opened, Tetsuro Toyoda, president of Toyota, visited the factory floor and noticed a worker named Joe struggling to install a rear taillight on a frame that had been produced at an odd angle. Toyoda looked at Joe's badge and said, "Joe, please pull the andon cord." Joe, with the entire executive team standing behind Toyoda, said he could fix it. Toyoda asked again. Joe said he could fix it. So Toyoda reached over, took Joe's hand, raised it to the cord, and together they pulled it.⁶

Joe was shaking. But when the line stopped, they fixed the problem together. Toyoda apologized—through a translator—for failing to communicate to Joe's managers how important it was that workers pull the cord. He told Joe that the workers were the most important part of the factory.

⁶ Charles Duhigg, *Smarter, Faster, Better: The Secrets of Being Productive in Life and Business* (New York: Random House, 2016).

By lunchtime, everyone in the plant had heard the story. The next day, reportedly, the cord was pulled more than a dozen times. Within a month, the plant averaged around a hundred pulls a day.⁷

The system was in place from day one. But people didn't use it until a leader, the most senior leader in the building, physically demonstrated that it was safe. And even then, it didn't happen all at once. A dozen the next day. A hundred a month later. Trust built gradually, one pull at a time, as workers watched what actually happened (or didn't happen) when someone asked for help or stopped the line.

Under that system, absenteeism dropped from roughly 20 percent to under 3 percent. A 1987 internal GM report I found in the archives at Wayne State University captured the philosophy in a single sentence:

"When a problem occurs, the emphasis is on finding and eliminating the cause rather than finding someone to blame."

Same American autoworkers. Different management system. Better results.⁸

Another Plant, Same Workers, New Leader

I saw a version of that transformation at my own plant. GM had sent a number of managers to NUMMI in the mid-1980s to learn Toyota's approach firsthand. They were sometimes called "NUMMI commandos"—people who came back with a fundamentally different idea of how to lead a factory. Larry Spiegel was one of them.

In 1996, after a string of major quality problems at the General Motors Powertrain Livonia Engine Plant—in my hometown, about a mile from where I grew up—GM brought Larry in as the new plant manager. This was Bob's plant—he was the plant superintendent, effectively the second-in-command, the assistant plant manager. The same superintendent I described earlier, the one whose management philosophy you could summarize as "beat down on them." That was the culture Larry inherited.

Partway through his first year, Larry called an all-hands meeting—hourly and salaried employees together. He stood up and told the workforce, plainly, that the days of blaming

⁷ Duhigg, *Smarter, Faster, Better*

⁸ "NUMMI Management Practices: Executive Summary" (General Motors, January 1987), Don Ephlin Papers, Walter P. Reuther Library, Wayne State University, Detroit, MI.

the workers were over. The problem wasn't the people. The problem was the old management style. And he was there to change it. And we would succeed *together*.

He meant it. He listened. He started building relationships out on the shop floor instead of demanding compliance. It wasn't a slogan or a kickoff event that faded after a few weeks. Larry was laying the groundwork for a genuinely different way of running the plant.

I was there for the first year of that transformation. I'd already committed to graduate school, so I left before seeing the full arc play out. But I kept in touch with people at the plant. Within a few years, Livonia went from being the worst-performing engine plant in the auto industry to top quartile. Same plant. Same union. Same hourly workforce Bob had spent years beating down on.

When I started at Livonia in 1995, the plant already had a handful of people on staff whose job was something like Lean advisors—most of them hired in from Nissan and from Toyota suppliers. GM Powertrain headquarters had hired them and sent them to our plant. The previous plant manager and Bob hadn't asked for them and didn't want their help. Their office was tucked away on a mezzanine level, about as far from the plant floor as you could get. A few of them took me under their wing anyway. I'd walk the floor with them, ask questions I'd have been embarrassed to ask anyone else, argue with them about what we were seeing. I felt safe with them, and I think they felt safe with me. Larry extended that safety across the plant.

Years later, I traded emails with Larry and asked why he'd kept Bob on. His answer surprised me. Larry and Bob had been fraternity brothers at General Motors Institute (GMI). They'd come up through the same GM system, trained in the same management style. Larry told me plainly that before NUMMI, his own approach wasn't all that different from Bob's. Which is not what I wanted to hear, because I had a very tidy story in my head where Larry was the good manager and Bob was the bad one, and that story did not have room for Larry having once been a version of Bob. The difference was that Larry had what he called "a life-altering experience"—he'd been shown a better way and given the chance to execute it in an environment that supported it. Bob never had that chance. The problem wasn't the person. It was the experiences the system had given them.⁹

I didn't fully understand at the time why Larry's approach worked. I just knew it was different—viscerally, obviously different from what Bob and the previous plant manager had built. It would take me years of consulting, writing, and studying Toyota's culture

⁹ Larry Spiegel, personal correspondence with Mark Graban, 2010.

before I could name what Larry was doing. He was making it safe to speak up. He was building the precondition that all the problem-solving tools depended on.

Bob hadn't just been unpleasant; he had been expensive. The plant had been paying the silence tax for years—every suggestion that never got made, every problem that got worked around instead of reported, every engineer who learned to stop asking. By the time Larry arrived, Livonia was the worst-performing engine plant in the industry.

Silence compounds.

What It Looks Like When the System Works

Mike Hoseus, who would later become a manager at Toyota's Georgetown plant, was a new team member being trained in Japan. He accidentally scratched a car. His first instinct was to let it go—nobody would probably see the scratch, and nobody would know he'd made it. But he wanted to test whether they really meant what they said about admitting mistakes. So he pulled the andon cord.¹⁰

The team leader came, helped fix the problem, and showed Hoseus how to hold his air gun in a way that was less likely to slip. The team leader, Hoseus recalls, "didn't seem angry at me for making the scratch."

That afternoon, at the group meeting, the Japanese managers brought up Hoseus's name. He braced himself. This was the part he'd been expecting—the public correction, the example made of the new American who damaged a car on the line. He watched their faces, waiting for it.

They started clapping. The whole group, clapping and smiling, shaking his hand, and patting him on the back. They were applauding him for admitting the mistake. He confirmed through his interpreter what was actually happening, and, as he recalls:

"I felt like a million bucks, and guess what I did the next time I made a mistake?"

Two things happened in that story. First, Hoseus felt safe enough—or maybe just brave enough—to test the system, to pull the cord and see if the response matched the promise. Second, the system responded. Someone showed up who could actually help. The problem got addressed. And then his honesty was rewarded publicly.

¹⁰ Jeffrey K. Liker and Michael Hoseus, *Toyota Culture: The Heart and Soul of the Toyota Way* (New York: McGraw-Hill, 2008)

Take either one away, and the system breaks. If people don't feel safe, they won't pull the cord. If nothing useful happens when they do, they'll stop.

A Culture That Changed—and Then Changed Back

Ford CEO Alan Mulally arrived from Boeing in 2006, stepping into a company that had just posted a \$12.7 billion loss. One of the first things he changed was the weekly Business Plan Review, where every senior leader reported on their part of the business with red, yellow, and green indicators. For months, every slide came back green. The turn came when Mark Fields, then head of Ford's Americas division, finally showed a red slide on a quality issue delaying the launch of the Ford Edge.

Former Ford product development leader Jim Morgan was in the room that day. As Jim told the story at an LEI Summit years later, the whole group expected Fields to be fired on the spot. His dry line, delivered to an audience laugh: "Oh, that's a shame. I really liked that guy." Mulally applauded instead. From that week on, other leaders started showing red. The problems that had been hidden came out where they could be worked on. Employee engagement climbed to 92 percent by the time Mulally retired in 2014.¹¹

The culture didn't hold.

Mark Fields, who succeeded Mulally, had been in the room for all of it. He'd lived the system. He knew the behaviors. But as Bryce Hoffman, author of *American Icon*, told the Detroit News, Fields failed to follow "this amazing management system" Mulally had left behind. Hoffman characterized Fields' tenure as "a lot of talk from Mark and not a lot of action."¹² The Business Plan Review discipline, the "no sniping" norm, the openness—all of it required active, visible reinforcement from the top. Without it, the old culture reasserted itself.

¹¹ [ENDNOTE]: Jim Morgan recounted being in the room for the Fields red-slide moment at an LEI Lean Transformation Summit, likely 2018. [AUTHOR NOTE: Confirm year and venue with Jim Morgan by email before publication.] Morgan is co-author with Jeffrey Liker of *The Toyota Product Development System: Integrating People, Process and Technology* (Productivity Press, 2006) and appeared on Lean Blog Interviews episode 109, January 2011, <https://www.leanblog.org/2011/01/jim-morgan-ford-lean-product-development/>. The Business Plan Review system, the green-slide pattern, and the Edge quality issue are documented in Bryce Hoffman, *American Icon: Alan Mulally and the Fight to Save Ford Motor Company* (Crown Business, 2012).

¹² "Ford CEOs Have Always Had a Power Struggle," *Detroit News*, May 29, 2017, <https://www.detroitnews.com/story/business/autos/ford/2017/05/29/ford-ceos-power-struggle/102301632/>.

When Fields was replaced as CEO in 2017, one of the concerns cited was what one NBC News report characterized as "a worrisome shift in Ford's corporate culture,"—a return to the turf wars and internal politics that Mulally had worked to dismantle.¹³ Bill Ford Jr. himself put it plainly:

"When Alan was here, he engendered such a sense of can-do and optimism. And maybe we lost a little of that."¹⁴

Nobody decided to break the culture. Unfortunately, it just stopped being actively sustained.

Toyota expert Jeff Liker pointed me to something I'd missed. The andon system depends on having a dedicated team leader whose job is to respond when the cord is pulled. Jamie Bonini, president of Toyota's Production System Support Center (TSSC), made the point at the 2026 LEI Lean Summit: "It's impossible to do TPS without the team leader." At Toyota, one offline team leader supports every four to six frontline workers. That person arrives within eight seconds of an andon pull. Their job is to respond, problem-solve, and train.¹⁵

That team leader role, the kind of investment Toyota makes at the frontline, is the connective tissue that sustains a culture of raising problems. Ford didn't invest in it. You can change what happens in the executive conference room, but if the frontline support structure isn't there, the culture erodes when the leader who built it moves on.¹⁶

As they said back at GM,

"We'll save money no matter what it costs us."

¹³ Paul A. Eisenstein, "Before He Was Ousted, Ford's CEO Wanted to Fire His Second in Command," NBC News, June 1, 2017, <https://www.nbcnews.com/business/autos/ford-ceo-tried-fire-his-president-then-got-booted-himself-n767046>.

¹⁴ "Ford CEOs Have Always Had a Power Struggle."

¹⁵ Jamie Bonini (presentation, Lean Enterprise Institute Lean Summit, Houston, TX, March 12-13, 2026).

¹⁶ Jeff Liker, personal communication with the author, 2025.

By 2025, Ford had issued 152 vehicle recalls. The highest ever recorded by an automaker in a single calendar year.¹⁷

I can't draw a straight line from the culture shift to the recall numbers. Quality problems have many causes. But I know which direction I'd bet. When people feel safe raising problems early, fewer problems reach the customer. When the culture reverts to one where truth-telling is risky, and nobody's quite sure what happens when you raise a concern, problems travel further downstream before anyone catches them.

When Firing Replaces Fixing

Here's a smaller story that illustrates the same gap, from a different angle. A Lean consultant told me about a food manufacturer where an employee was using an industrial mixer to make a ground-meat product. They got distracted by a co-worker who had a question. They pressed the start button without realizing they'd left a large mixing spoon inside. The spoon destroyed the mixer.

Sadly, the company fired the worker (against the consultant's advice). They replaced the mixer. And they apparently did nothing to prevent the mistake from happening again. They'd fired an "idiot," as they probably saw it, without asking why the system allowed the mistake in the first place.

It was a matter of time before a new employee made the same error. And they did. The company, as far as I know, treated each incident as an unfortunate coincidence best left unsolved.

A more effective approach would have been some form of mistake-proofing—wiring the mixer, so it can't start until the spoon is placed back on its holder, for instance. Without that kind of process thinking, how many employees and how many mixers would the company go through?

Firing the person felt like accountability. It was actually the opposite. Nobody asked "what?" or "why?" or "how?" They asked "who?"—and once they had a name, they stopped thinking.

The Missing Precondition

¹⁷ National Highway Traffic Safety Administration, Recalls by Manufacturer, 2025, <https://datahub.transportation.gov/Automobiles/NHTSA-Recalls-by-Manufacturer/mu99-t4jn>.

When a transformation stalls, the diagnosis is usually technical. The training wasn't robust enough. The facilitators weren't expert enough. The project scoping missed. Those diagnoses aren't wrong. I've seen all of them, and sometimes the fix is exactly that—better training, better coaching, better-scoped work.

Every story in this chapter turns on the same hinge. Someone saw a problem. They said something or they didn't. The training was fine. The facilitators were fine. The projects were fine. What was missing wasn't technical. The rest of the system—the tools, the methods, the data—was waiting for an input that wasn't coming.

The tell is the cycle. Training. Problems still don't surface. So we invest in more training. Or different training. Or a more expensive consultant. Nobody stops to ask why the problems aren't surfacing in the first place. Which is, if you think about it, a pretty lousy example of problem-solving. Assume the root cause, jump to a countermeasure, repeat one that didn't work the first time. The thing the training was supposed to teach everyone to stop doing.

Most senior leaders feel safe speaking up, which is exactly why they have trouble seeing the problem.

The people on the other side of the desk learned a different lesson. They learned that raising problems costs something, or they learned that raising problems changes nothing. Either way, they went quiet.

If problems aren't surfacing, improvement can't happen. You can train all you want. And for what?

Chapter 2: What Psychological Safety Is (and Isn't)

The term "psychological safety" has become popular enough to be misused—sometimes innocently, sometimes strategically, often in ways that make it harder for the idea to do its real work. This chapter is about what the term actually means and what it doesn't. It covers Amy Edmondson's distinction between nice and kind from her 2025 HBR article, Timothy Clark's four stages viewed through a Lean lens, and a workshop exercise I've run with thousands of people that surfaces the specific acts of workplace vulnerability most of us find hardest. Safety and comfort aren't the same thing—and getting that

wrong is how a genuinely useful concept ends up weaponized as a shield against feedback.

Chapter 3: Fear and Futility

This chapter names the two forces keeping people quiet. Fear is the one leaders already understand—the bully CEO, the consequences people have seen or heard about. Futility is the one leaders usually miss: when people stop speaking up because experience has taught them nothing will change either way. I draw on Ethan Burris's research and on Dr. Robert Maurer's work on the amygdala and behavior change to explain why most speak-up initiatives are aimed at the wrong problem, and I tell one of my own worst days at GM to show what it looks like when both forces land on the same person at the same time.

Part Two: What Leaders Do Differently

Chapter 4: Model

The next four chapters—Model, Encourage, Enable, Reward—are about behavior. Four habits you can start practicing this week, mapped to the two forces from Chapter 3. Chapter 4 is the foundation: if you want people to admit mistakes and say "I don't know," you have to go first. Modeling isn't a memo or a town hall announcement. It's what you do in the next meeting when you don't know the answer to someone's question, and in every meeting after that. The chapter draws on Toyota leaders and a handful of healthcare executives I've worked with, all of whom discovered that modeling vulnerability was harder than it sounds and more contagious than they thought it would be.

Chapter 5: Encourage

Modeling creates permission. It doesn't create expectation. Most improvement cultures stall in the gap between the two—the leader has admitted a mistake, the team appreciates the gesture, and then nothing else happens. This chapter is about closing that gap through specific habits: asking questions that make honest answers easier to give, walking the gemba in a way that actually surfaces problems rather than performs interest in them. Steven Spear's see-solve-share framework gets a fourth step in this book, because for most organizations the missing link is speaking up in the first place.

Chapter 6: Enable

Coming soon...

Modeling gets people willing to speak up. Encouragement gets them speaking. Enabling is what decides whether anything comes of it. This chapter is about the gap between the suggestion box being open and the organization actually being able to do something with what shows up inside it—the PDSA that "didn't work" and made the team decide they're bad at improvement, the A3 that became paperwork instead of a coaching conversation. The concept running through the chapter is what I'm calling Improvement Theater—activity that looks like capability from the outside and isn't.

Chapter 7: Reward

Coming soon...

Most leaders I work with have stopped yelling. They've read the books, been to the workshops, and genuinely believe in a better culture. Many of them are stuck at "nice" without realizing it—the response that makes the leader feel okay and teaches the person who spoke up that speaking up didn't actually change anything. This chapter draws on Karyn Ross's distinction between nice and kind, and spends most of its pages on what most leaders most need help with: what to say and do in the moment after someone brings you a problem, including the harder moments when the honest answer is no.

Part Three: Is It Working?

Chapter 8 : Measure Progress

Coming soon...

At some point you're going to want evidence. Your boss might want it. Your board might want it. You might need it yourself, because doing the right things without seeing results is how leaders burn out on culture work. This chapter covers two ways to know: direct measurement, which means doing a survey in a way that produces honest data and avoids the most common traps, and indirect measurement, which means watching what the organization is already telling you through incident reports, idea submissions, and the state of the huddle boards. It includes polling data I've collected from more than a thousand Lean practitioners over the last three years, along with what to do when the score gets worse before it gets better.

Chapter 9: Start This Week

Coming soon...

This will be the shortest chapter in the book. By this point the reader has the diagnosis from Part 1 and the behaviors from Part 2. The only question left is what to do Tuesday morning. The premise is modest: pick one team, one meeting, one behavior change, and run the experiment for a month. Let results do the persuading rather than announcements.

Appendix

Recommended Reading

Coming soon in the final edition.

Planned titles: Amy Edmondson, [The Fearless Organization](#); Timothy Clark, [The 4 Stages of Psychological Safety](#); Mark Graban, [The Mistakes That Make Us](#); Jeff Liker and Mike Hoseus, [Toyota Culture](#); Kiyoshi "Nate" Furuta, [Welcome Problems, Find Success](#); Katie Anderson, [Learning to Lead, Leading to Learn](#); Stephen Shedletzky, [Speak-Up Culture](#); Mark Graban, [Lean Hospitals \(3rd Edition\)](#); Mark Graban, [Measures of Success](#). Robert Maurer books

Endnotes

Endnotes will be compiled in the final edition.

About the Author

Mark Graban is an internationally recognized consultant, author, and speaker with experience in healthcare, manufacturing, and startups. He is the author of *The Mistakes That Make Us: Cultivating a Culture of Learning and Innovation*, *Lean Hospitals*, *Measures of Success*, *Healthcare Kaizen*, and the anthology *Practicing Lean*—three of which have received the prestigious Shingo Publication Award.

Mark hosts the "My Favorite Mistake" and "Lean Blog Interviews" podcasts and is a Senior Advisor to the technology company KaiNexus.

He holds a BS in Industrial Engineering from Northwestern University, an MS in Mechanical Engineering, and an MBA from the MIT Sloan "Leaders for Global Operations" program.

Learn more at MarkGraban.com.

Also by Mark Graban

- *The Mistakes That Make Us: Cultivating a Culture of Learning and Innovation*
- *Lean Hospitals: Improving Quality, Patient Safety, and Employee Engagement (3rd Edition)*
- *Healthcare Kaizen: Engaging Front-Line Staff in Sustainable Continuous Improvements*
- *The Executive Guide to Healthcare Kaizen*
- *Practicing Lean: Learning How to Learn How to Get Better... Better*
- *Measures of Success: React Less, Lead Better, Improve More*