DECIDE IN 30

THE HIDDEN DISEASE WITHIN EVERY TEAM

Poor decision-making is sabotaging your results

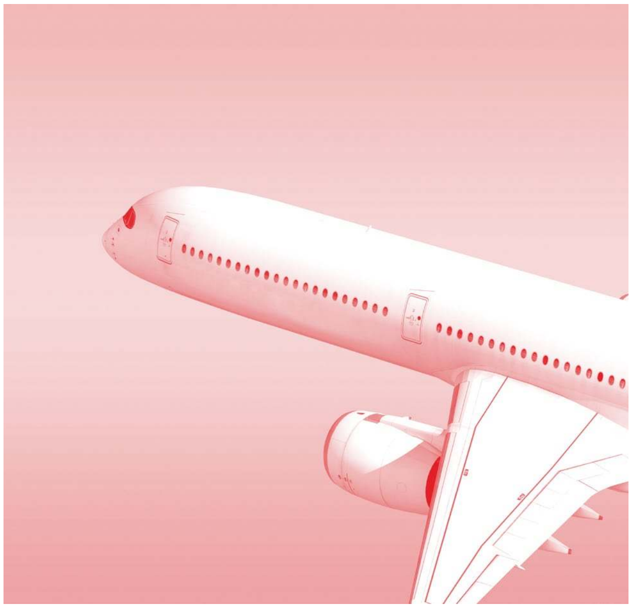
Let's Start With a Miracle

On January 15, 2009, at precisely 3:27 PM, Captain Chesley "Sully" Sullenberger faced every pilot's worst nightmare. US Airways Flight 1549 had just struck a flock of Canadian geese at 2,800 feet, instantly destroying both engines.

With both engines destroyed by bird strikes and New York City below, Sullenberger and his crew executed what the NTSB later called a "masterclass in decision-making under impossible pressure."

What made this a miracle wasn't luck—it was a decision-making system. In those critical moments, Sullenberger's team flawlessly executed structured decision-making: they defined clear authority, discussed options through established protocols, decided with decisive clarity, and owned their roles completely. The result? Everyone survived.

This same decision-making framework that saved lives over the Hudson is precisely what separates thriving organizations from failing ones.



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The Hidden Disease

Walk into any growing organization and witness a familiar scene: talented managers huddled outside the CEO's office, waiting for approval on decisions that should have been made weeks ago. Meanwhile, the CEO sits buried under choices ranging from strategic to mundane.

Everyone's frustrated. Nothing moves fast enough. When decisions finally get made, half the team doesn't support them.

Your decision-making process is sabotaging your results.

Not your strategy. Not your people. Your decision-making process.

Harvard's Amy Edmondson found that fear-driven decision-making creates what organizational psychologists call "defensive decision-making." Leaders delay choices, seek consensus instead of clarity, and create organizations paralyzed by analysis rather than energized by action.

Organizations that should thrive instead find themselves weakened by committee thinking and defeated by competitors who simply decide faster.

"Your decision-making process is sabotaging your results."

Realizing the Costs

Here's the insidious part: most organizations are completely unaware of how decision-making problems are sabotaging their results. They see the symptoms—missed deadlines, frustrated customers, disengaged employees—but miss the root cause.

Consider Boeing's 787 Dreamliner development. Boeing assembled teams from over 50 suppliers across multiple countries, each with deep expertise. Yet the program suffered massive delays and cost overruns because no one could decide who had authority to make critical choices when problems arose.

When suppliers encountered conflicts between specifications, schedules, and costs, decisions stalled in endless consultation loops. As one Boeing engineer reflected: "Everyone who works for Boeing knows that poor management decisions, poor planning, and leadership" delayed the 787 program. The company had distributed design authority without creating clear decision-making processes.

Meanwhile, the BP Texas City explosion of 2005 killed 15 workers partly because critical safety decisions were delayed for hours while operators struggled to reach decision-makers. Years of cost-cutting had created a culture where safety concerns weren't heard and warning signs were systematically ignored.

Teams either flourish or flounder based on one thing: their decision-making process.

The Operating System for Better Decisions

After studying decision-making failures across hundreds of organizations, we developed DecideOS: a systematic framework that addresses the three core barriers leaders face when making and delegating decisions:

CAPABILITY
Do they know enough?

SPEED
Will they decide quickly enough?

BUY-IN
Will others support decisions they didn't make?

DecideOS consists of four essential steps that research shows accelerate decision quality while building organizational commitment:

DEFINE
who makes the decision and what decision needs to be made.

DISCUSS
using structured dialogue that ensures all perspectives are heard.

DECIDE
with clear authority and explicit commitment.

OWN
the decision as if you made it yourself, regardless of your initial position.

This isn't management theory. It's the framework that saved Flight 1549, and it's how the best organizations consistently make better choices faster.

DEFINE | DISCUSS | DECIDE | OWN

Define with Precision

Most organizational decisions fail because participants have different understandings of what decision is actually being made. Research published in Organizational Behavior and Human Decision Processes found this confusion caused 85% of failed decisions—not poor analysis or bad judgment.

Netflix solved this with "decision memos," brief documents that clearly stated what decision needed making, who was authorized to make it, and by when. These weren't bureaucratic requirements; they were cognitive tools that aligned everyone's mental models before discussion began.

Captain Sullenberger's cockpit exemplified this clarity. The moment both engines failed, established protocols instantly clarified roles: the captain had ultimate authority, the co-pilot would run emergency checklists, flight attendants would prepare the cabin. No confusion, no debate, no delay.

DEFINE SOUNDS LIKE:

"We need to decide whether to launch the new product feature by Q2 or delay until Q3. Sarah, as product manager, you're the decision-maker. We need this decided by Friday so engineering can finalize sprint planning."

DEFINE DOESN'T SOUND LIKE:

"Let's discuss the product roadmap and see what everyone thinks we should do."

DEFINE DISCUSS DECIDE OWN

Discuss with Structure

People don't need to agree with decisions to support them, but they do need to feel heard in the process. The framework is "listen, position, listen." Create space for all perspectives without judgment. Then, as a decision-maker, share your initial thinking. Finally, listen again to see if new information should influence the final choice.

A longitudinal study tracking 1,048 employees across 90 work teams found that participation in decision-making was one of the strongest predictors of team effectiveness over time. When people felt heard in decisions, they were more likely to speak up with problems and ideas in the future.

The crew of Flight 1549 exemplified this principle. Sullenberger had trained his teams in Crew Resource Management, a communication system that encouraged flight attendants and co-pilots to speak up with critical information. During the emergency, co-pilot Skiles continuously fed Sullenberger data, while the flight attendants reported the cabin conditions. Everyone's voice was heard and integrated.

DISCUSS SOUNDS LIKE:

"Before I share my thinking, I want to hear from everyone. What concerns do you have about launching in Q2? What opportunities might we miss if we delay?... Okay, based on what I'm hearing, I'm leaning toward the Q2 launch because of the competitive window, but I'm concerned about the testing timeline Sarah mentioned. Talk me through that..."

DISCUSS DOESN'T SOUND LIKE:

"I've decided we're launching in Q2. Any questions?"

DEFINE › DISCUSS › DECIDE › OWN

Decide With Courage

The biggest barrier to good decisions isn't lack of information, it's the reluctance to decide at all. Fear of making wrong decisions often produces worse outcomes than making imperfect decisions quickly and adjusting based on results.

Sullenberger's Hudson landing embodied this principle. Within seconds of the bird strike, he rapidly evaluated three options: return to LaGuardia, divert to Teterboro Airport, or attempt a water landing. Air traffic control offered the first two alternatives, but Sullenberger quickly calculated they lacked sufficient altitude. "We're gonna be in the Hudson," he announced—a definitive choice made with incomplete information but clear reasoning.

Boeing's 787 program suffered from the opposite problem. When teams identified conflicts between design specifications and manufacturing constraints, decisions bounced between committees for months. Each group sought perfect information before committing, but perfect information never arrived. Meanwhile, suppliers waited, costs accumulated, and delivery dates slipped.

DECIDE SOUNDS LIKE:

"Thank you for the discussion. I've heard everyone's input. We're going with the Q2 launch. Sarah, I want you to work with engineering on a risk mitigation plan for the testing timeline. Let's reconvene next Tuesday to finalize implementation details."

DECIDE DOESN'T SOUND LIKE:

"This is a tough decision. Let me think about it and get back to everyone next week."

DEFINE | DISCUSS | DECIDE | OWN

Own With Commitment

The final step addresses the gap between making decisions and seeing them through to results. Post-decision alignment distinguishes high-performing teams from average ones. Fair and inclusive decision-making processes predict implementation success better than whether people achieve the outcomes they desired.

Netflix operationalized this through "disagree and commit" conversations. After decisions were made, team members voiced lingering concerns, then publicly committed to supporting the decision. This created a clear transition from decision-making mode to implementation mode.

Flight 1549's crew demonstrated ultimate ownership. Once Sullenberger announced the Hudson landing, every crew member immediately committed to their role: Skiles focused on emergency checklists, flight attendants prepared passengers, and everyone worked seamlessly toward survival. No second-guessing, no resistance, no freelancing.

OWN SOUNDS LIKE:

"I know some of you had concerns about the Q2 timeline. I want to hear those one more time, then I need everyone's commitment to making this successful… Okay, everyone clear on next steps? Any concerns about your ability to deliver on your part?"

OWN DOESN'T SOUND LIKE:

"I hope everyone can support this decision," followed by hallway conversations about why it won't work."

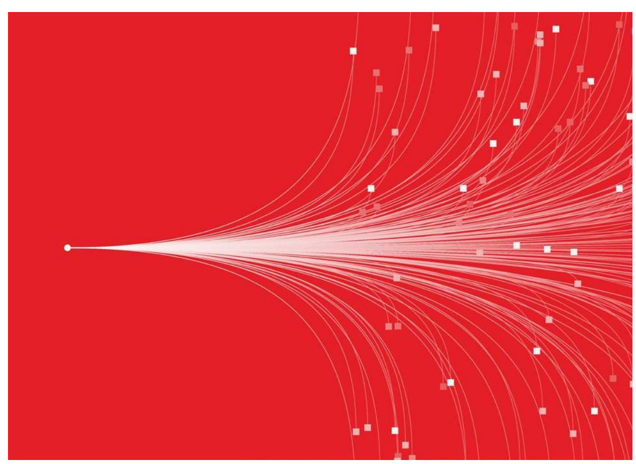
The Compound Effect of Better Decisions

Organizations that master DecideOS don't just make individual choices faster—they create compound advantages. Better decisions create better outcomes, which build confidence and trust, which enable even better decisions in the future.

A study of 160 management teams found that teams with structured decision-making processes showed continuous improvement in decision quality over time, while teams with unclear processes showed declining performance.

Compare this to traditional organizations where each decision must navigate multiple approval layers, political considerations, and fear of career consequences. Even when these organizations make good individual decisions, the process is so slow and exhausting that they can't capitalize on compound advantages.

Sullenberger's crew exemplified this virtuous cycle. Years of practicing structured decision-making built the trust and muscle memory that enabled split-second coordination during the emergency. Their collective competence wasn't accidental, it was the result of systematically good decision-making processes practiced over time.



Will You Be Ready?

The choice facing leaders isn't whether to improve decision-making, it's how to do it systematically and well. In a world of accelerating change, the greatest risk isn't making wrong decisions; it's failing to make decisions at all.

Captain Sullenberger's "Miracle on the Hudson" wasn't just an aviation triumph, it was a decision-making masterpiece. The crew had all the technical skills, safety knowledge, and emergency procedures necessary to handle the crisis. What made the difference was their decision-making culture: clear authority, structured communication, decisive action, and complete commitment to shared outcomes.

Today's organizations face similar tests daily. The question is: when the next critical challenge emerges in your organization, whether it's a market opportunity, operational crisis, or strategic crossroads, will your decision-making culture be ready?

FOOTNOTES

[1] National Transportation Safety Board. (2010). Loss of thrust in both engines after encountering a flock of birds and subsequent ditching on the Hudson River: US Airways Flight 1549. Aircraft Accident Report, NTSB/AAR-10/03.

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