

Culture Shock

Defining acceptable behavior in a 'just culture' has its pitfalls.

BOOKS

Just Culture: Balancing Safety and Accountability

Dekker, Sidney. Aldershot, England, and Burlington, Vermont, U.S.: Ashgate, 2007. 165 pp. Figure, table, index.

“No longer do we see accidents as meaningless, uncontrollable events,” Dekker says. “On the contrary: accidents are evidence that a particular risk was not managed well enough.”

From there it is only a short step to perceiving an accident as a “failure” of risk management. Someone’s job wasn’t done right. Someone must be blamed.

That normal — if questionable — reaction to an accident stands in the way of an opposite trend in risk management, which is to look at the accident as a systemic failure, not the error of a particular person or persons. According to this view, the important thing is to create an atmosphere of organizational trust, in which people readily acknowledge problems that could lead to an accident, or that were involved in an incident or accident, so that the causal factors can be systematically resolved.

There is a tension between these two ways of looking at a situation. A “no blame” culture can encourage transparency and allow the organization, not just individuals, to learn from mistakes. Realistically, however, no organization can afford an absolute hands-off policy toward people associated with bad events. Not only does it go against human nature, it doesn’t acknowledge that negligence and irresponsibility exist.

Trying to reconcile these two value systems has led to a keen interest in the idea of a “just culture” — one that is neither weighted toward finding fault nor infinitely tolerant. Fairness and justice are its keynotes.

“A just culture is something very difficult to define, as ‘justice’ is one of those essentially contested categories,” Dekker says. “Essentially contested’ means that the very essence, the very nature, of the concept is infinitely negotiable. But that does not mean we cannot agree, or make some progress on, some very practical problems related to what we could call a just culture.”

In the abstract, it is easy enough to come up with a verbal formula to describe a just culture. Most people would agree that there is a vast realm in which honest mistakes take place, and that those who make them ought not to suffer as a result, but a “line” separates that realm from negligent or even criminal behavior. Nevertheless, says Dekker, “We delude ourselves that there should be consequences for operators or practitioners who ‘cross the line.’ ... We don’t realize that lines don’t just exist ‘out there,’ ready to be crossed or obeyed, but that we — people — construct those lines, that we draw them differently every time, and that what matters is not *where* the line goes — but *who* gets to draw it.”

Dekker cites one typical, and long, definition of negligence that uses terms such as “normal standard,” “reasonably skillful,” “reasonable care” and “prudent,” with a failure to meet such benchmarks considered negligent.



“Rather than clarifying which operational behavior is ‘negligent,’ such a characterization shows just how complex the issue is,” Dekker says. “There is an amazing array of judgment calls to be made. Just see if you, for your own work, can (objectively, unarguably) define things like ‘normal in the community,’ ‘a reasonable level of skill,’ ‘a prudent person,’ ‘a foresight that harm may likely result.’ ... And don’t we all want to improve safety precisely because the activity we are engaged in can result in harm?”

In addition, Dekker says, judgments about whether an act was negligent, reckless or otherwise “over the line” are subject to hindsight bias. That is, knowing the outcome, it is almost impossible to understand the situation as it appeared to someone who didn’t have foreknowledge of what would happen.

“Of course, it is not that making such judgments is impossible,” Dekker says. “In fact, we probably do this quite a lot every day. It is, however, important to remember that judgment is exactly what [it is]. ... What matters is which processes and authorities we in society (or you in your organization) rely on to decide whether acts should be seen as negligent or not.”

He is very concerned about the trend toward mixing accident investigations with judicial proceedings. (See “Deterring Criminalization,” *ASW*, 3/08, p. 12.) “As long as there is fear that information provided in good faith can end up being used by a legal system, practitioners are not likely to engage in open reporting,” he says. “Many admit that they will only file a report when there is the chance that other parties will disclose the incident (for example, an air traffic controller may think that a pilot will report a close call if he or she does not), which would make the event known in any case. This puts practitioners in a ‘Catch-22’ [an insoluble dilemma]: either report facts and risk being persecuted for them, or not report facts and risk being persecuted for not reporting them. Many seem to place their bet on the latter: rather not report and cross [their] fingers that nobody else will find out either.”

There is no evidence that a judicial system will improve safety, Dekker says: “The idea that a charged or convicted practitioner will serve as an example to scare others into behaving more prudently is probably misguided: instead, practitioners will become more careful only in not disclosing what they have done. The rehabilitative purpose of justice is not applicable either, as there is usually little or nothing to rehabilitate in a pilot or a nurse or air traffic controller who was basically just doing his or her job. Also, correctional systems are not equipped to rehabilitate the kind of professional behaviors (mixing medicines, clearing an aircraft for takeoff) for which people were convicted.

“Not only is the criminalization of human error by justice systems a possible misuse of tax money — money that could be spent in better ways to improve safety — it can actually end up hurting the interests of the society that the justice system is supposed to serve.”

Despite the problems inherent in defining what is allowed in a just culture, Dekker says that many organizations adopt pragmatic solutions that work reasonably well. Those solutions, he says, derive from answering three central questions: Who in the organization gets to draw the line between acceptable and unacceptable behavior? What should be the role of domain expertise in judging whether behavior is acceptable or unacceptable? And how protected are safety data against judicial interference?

REPORTS

Safety Management Systems for Airports. Volume 1: Overview

Ludwig, Duane A.; Andrews, Cheryl R.; Jester-ten Veen, Nienke R.; Laqui, Charlotte. Washington, D.C.: Transportation Research Board of the National Academies, Airport Cooperative Research Program (ACRP) Report 1. 2007. 39 pp. Figures, photographs, list of abbreviations. Available via the Internet at <www.trb.org/news/blurbs_detail.asp?id=7918> or from the National Academies.*

“This report provides a brief description of a safety management system (SMS) and is intended to be an easy-to-read, quick introduction to SMS for airport directors and their governing boards,” the report says. “It describes the advantages associated



with instituting such a system and explains the four components or pillars (safety policy, safety risk management, safety assurance and safety promotion) that are part of an SMS. The report also provides the background information on the International Civil Aviation Organization's (ICAO's) requirements for SMS at airports and relates the experiences of airports located outside the United States in implementing SMS."

SMS represents a "next level" approach to safety management, which goes beyond analyzing past accidents and acting to remedy defects found to have been causal factors. It is based on prevention, not only cure. More than that, when an SMS is in place, prevention efforts are not random or brought about just by individuals; they are a fixed, standardized component of every level of an organization.

"A well-structured SMS provides a systematic, explicit and comprehensive process for managing risks," the report says. "This process includes goal setting, planning, documentation, and regular evaluation of performance to ensure that goals are being met."

Among the benefits of SMS for airports, the report says, are reduction of the direct and indirect costs of accidents; improved employee morale and productivity; logical prioritization of safety needs; legal compliance; more efficient maintenance scheduling and resource use; avoiding operational disruptions; and continuous improvement of operational processes.

After sections on ICAO guidance for airport SMS and the experience of airports outside the United States, the report considers a "Vision of SMS Implementation at U.S. Airports." It looks at FAA activities undertaken or planned under U.S. Federal Aviation Regulations Part 139, *Certification of Airports*. FAA has also published Advisory Circular 150/5200-37, *Introduction to Safety Management Systems for Airport Operators*.

The report lists steps that airport managements should be taking or planning to prepare for the SMS that ICAO and the FAA have envisioned:

- "Establish a safety policy and assign safety responsibility. Responsibility for overseeing

the SMS implementation must be assigned at an early stage. ... The first task is establishing a safety policy that reflects SMS principles.

- "Perform a gap analysis. Compare existing safety components with SMS program requirements and identify all elements that require development. A gap analysis frequently begins with a list of all the current operations and procedures that occur at the airport. One can then verify whether they are performed in accordance with SMS philosophies.
- "Develop a strategy for SMS implementation. This is essentially a roadmap that lays out the steps required to fully implement SMS. The experience of other airports using SMS may prove helpful in determining an efficient phased approach and transition plan.
- "Develop individual SMS elements. Following the roadmap, the processes that make up SMS must be developed, documented, reviewed and verified."

This overview will be followed by the development of a guidebook that will provide detailed information about how to develop an SMS at an airport. The guidebook is expected to be completed in the last quarter of 2008 and published as the second volume of this report in 2009.

WEB SITES

International Helicopter Safety Team,
<www.ihst.org>

In January 2006, industry and government leaders, following the U.S. Commercial Aviation Safety Team model, created the International Helicopter Safety Team (IHST). Team members represent helicopter associations, operators, manufacturers, regulatory authorities, research facilities and other groups from Canada, Europe, the United States and other countries.

A banner on each Web page highlights the IHST goal: "To reduce the [worldwide] helicopter accident rate by 80 percent by 2016."

IHST provides a considerable amount of information on its public site. Examples are:

- Safety analysis reports from Australia, Canada, the United Kingdom and United States, including titles such as *The U.S. Joint Helicopter Safety Analysis Team: Year 2000 Report to the International Helicopter Safety Team*, September 2007 (an analysis of 197 helicopter accidents in one year considered representative of accidents in other recent years);



- A list of member organizations with active links to their Web sites;
- *The Safety Management Systems Toolkit*, edition 1, a compilation of best practices and solutions from small, medium and large helicopter operators; airlines; industry groups; and governments. Using a performance-based approach, the 40-page document says it “helps the organization determine [its] level of compliance and develop an action plan to include the necessary components”; and,
- Fourteen categories of additional resource materials to support information presented in the tool kit, such as risk assessment tools, safety communications, safety training, performance measurements, forms, checklists and sample cases.

Commercial Aviation Safety Team, www.cast-safety.org/index.cfm

The Web site says that CAST “identifies the top safety areas through the analysis of accident and incident data; charters joint teams of experts to develop methods to fully understand the chain of events leading to accidents;

and identifies and implements high-leverage interventions or safety enhancements to reduce the fatality rate in these areas.”

CAST was formed in 1998 as a cooperative U.S. government–industry initiative to identify and implement safety enhancements to reduce the commercial aviation fatality rate in the United States. Its success has enabled it to expand internationally and form regional safety alliances to strategically target commercial air carrier accident prevention. Contact information for international partners and government and industry members is listed.

The Web site provides organizational background and descriptions of the three types of CAST joint safety teams (safety analysis, data analysis and implementation); the CAST Safety Plan; a list of safety enhancements completed or under way; its glossary and taxonomy; CAST reports (1998–2007); and PowerPoint presentations. All can be viewed in full text online, and printed or downloaded at no cost. Some documents are large, in color and contain figures and tables. ●



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— Rick Darby and Patricia Setze