

Professional misconduct does not explain the real cause of accidents

Issue 16- December 2015 Mario Poy and Diego Turjanski Icsi, Consultancy Team

Mario Poy

Doctor of ergonomic psychology, he specialises in human factors in the domain of risk management. He is particularly interested in management, research, technical assistance and training projects in the defence, civil aviation, (petroleum) energy,



metallurgy, chemical and mining sectors.

Diego Turjanski

Psychologist and specialist in human and organizational factors of industrial safety, Diego's work focuses on consultancy and support projects in the aerospace, energy and petrochemical sectors. He is co-director of the human factors training module at the University of San Andrés in Argentina



'Professional misconduct' is a common explanation for accidents. This 'label', like many others that are widely used (lack of competence, clumsiness, overconfidence, carelessness, poor decision-making, etc.), all share a common feature; the cause of an accident or incident is said to be due to the behaviour (or attitude) of a frontline employee. However, this approach takes us nowhere: accidents happen because the person driving, flying or carrying out a critical task took an 'unprofessional' decision, and that is the end of it.

The fact is that even though these explanations give the impression of giving meaning to a tragedy, they serve very little purpose in terms of safety management.

First, 'professional misconduct' is usually a knee-jerk reaction to describe a phenomenon when, in reality, we are not able to fully understand the reasons for the actions of another human being. It is almost always only identified after an accident: the analyst reports that the cause of the accident was a set of poor or 'unprofessional' decisions taken by the actors involved.

However, knowing the outcome of an event strongly influences our perception of the facts that preceded it. In other words, knowing that an action caused an accident leads us to think that it should have been 'obvious' that the outcome would be catastrophic if such-or-such a decision was taken. However, the idea that something was 'obvious' (and the evidence for this is worth investigating!) does not address the most important point: why is it that what is obvious to us in retrospect was not obvious to those involved in the situation? Ultimately, it is a hindsight bias - a phenomenon widely studied by cognitive psychology - that attributes the cause of an accident to 'professional misconduct', as this gives 'meaning' (which incidents or accidents, by definition, temporarily destroy) to something that is otherwise inexplicable.

On the other hand, 'professional misconduct' usually conceals problems that are both complex and critical. The statement (and others) is no help at all

when examining the conditions or organizational context (technology, processes, leadership, training policies, among others) in which actions took place. In other words, the behaviour of people in accidents should be considered as a symptom and not the cause; not as a variable that explains an event but as the variable that needs to be explained.

If someone actually took an 'unprofessional' decision, the most pertinent question that must be answered is: why has this happened? From this perspective, the search for explanatory factors at this level is fundamental.

« Knowing that an action caused an accident leads us to think that it should have been 'obvious' that the outcome would be catastrophic if such -or-such a decision was taken »



Finally, to conclude that an accident was due to 'professional misconduct' has a practical difficulty. In general, this type of conclusion suggests remedial actions that are consistent with the line of thinking. The most frequent actions (applying sanctions or retraining the employee) lead to (when implemented) individual solutions, while no action is taken to address the context that led to the outcome. In this sense, it is likely that the same - or similar- events will happen again, as the real causes have not been properly identified.

If one accepts that individual behaviour is a symptom of deeper problems, then we must implement strategies that can identify the source of the real problem.

References

Dekker, S. W. A (2005). Ten questions about human error. Lawrence. Erlbaum Associates, New York

Reason, J. (2009). El error humano. Editorial Modus Laborandi. Madrid

Reason, J. (2010). La gestión de los grandes riesgos. Principios humanos y organizativos de la seguridad. Editorial Modus Laborandi. Madrid

Our thoughts on safety culture at www.icsi-eu.org