Fallibility at Work

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Rethinking Excellence and Error in Organizations

palgrave
macmillan

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ISBN 978-3-319-63317-6 ISBN 978-3-319-63318-3 (eBook)
DOI 10.1007/978-3-319-63318-3

Library of Congress Control Number: 2017948701

Printed on acid-free paper

This Palgrave Macmillan imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Acknowledgements

While working on this book I have benefitted greatly from the support and encouragement of family and friends, and from the reflections and input from colleagues, students, and professionals who have agreed to meet and talk about fallibility at work. Special thanks to Bjørn Atle Bjørnbeth, Inga Bolstad, Kristine Borvik, Arne Carlsen, Anders Dysvik, Herman Egenberg, Tharan Fergus, Jarle Gimmestad, Ingun Grytli, Thomas Hoholm, Mette Kaaby, Espen Kvark Kvernbergh, Salvör Nordal, Helén Norlin, Erik Osmundsen, Mina Randjelovic, Ingvild Müller Seljeseth, Miha Skerlavaj, Morten Theiste, Ragnhild Elin Thoner, Ósk Vilhjálmsdóttir, Stian Westad, and Torbjørn Aanonsen. I would also like to thank my employer BI Norwegian Business School for funding my work and making it possible to publish it with Open Access.

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Introduction

Pilot Jarle Gimmestad sat in the cockpit at Oslo Airport one late evening, waiting for takeoff. "The flight was already delayed by one hour, and I was eager to get onto the runway. As usual, I was in dialogue with the co-pilot to make final adjustments before takeoff. Suddenly, the driver of the pushback tractor on the ground drew our attention to a wet substance that dripped from one of the wings and onto the asphalt below. It had already formed a stain on the ground. The driver hinted that there could be an oil leak from the wing or motor. He suggested that we should get the motor engineers out to identify the cause of the dripping." Gimmestad talked with his co-pilot about it. Together they concluded that the stain was too small to give cause for alarm, and continued to prepare for takeoff.

The pushback tractor driver was still concerned about the dripping. Now he started to count the number of drops per minute that still came from the wing, and reported it to the men in the cockpit. He also measured the size of the stain on the asphalt, to indicate how serious he thought the matter was. Gimmestad suggested to him that contributions to the stain on the ground could have come from other planes that

had been parked on the same spot earlier in the day. It is normal to find such stains near the gate: "I tried to get the driver down below to accept that explanation, but he was not convinced. Now I suggested that the substance dripping from the wing probably was only water, and nothing to worry about. I asked the driver to sniff the substance. He did that, and his verdict was that it had a chemical smell, and so was not water."

Gimmestad took in this information, talked with the co-pilot again, and decided to continue and get ready for takeoff. He had now taken the matter from an operations level, where you listen to advice and suggestions, to a leadership level, where the person in charge has to take an authoritative decision. With this move, dialogue and reflection close down, to be replaced by monologue and action: "Conditions are acceptable, we proceed to takeoff." The driver of the pushback tractor should now have understood that the matter was out of his hands, and closed. Instead, he persisted to voice his worry about the state of the plane. After a few seconds of hesitancy, he said: "Do you know what? I don't think you should do that." This remark woke up the pilot and got him to reconsider. Signals from the unassuming but persistent man on the ground finally got through to him. The pilot postponed takeoff and asked the motor engineers to do a thorough investigation of the source of the substance dripping down from the wing.

Once Gimmestad had made that decision, he left the cockpit and went down the stairs to talk to the man on the ground. "When we stood face to face, I got the impression that the driver thought I was angry and would reprimand him. Instead, I shook his hand, and thanked him for his professional behavior. I told him that exactly this sort of behavior is crucial in a proper safety culture." The driver of the pushback tractor does not have a formal role in the safety procedures leading up to takeoff. His sole job is to push the plane out of the position at the gate. He is normally not part of the ongoing dialogue, and as such has to impose himself and take a step forward to demand attention, outside the normal procedure. In this particular case, the driver addressed his concerns to the pilot in an apologetic manner, downplaying his own importance, but at the same time repeatedly insisting that his observations should be taken seriously.

Reflecting afterward on his own behavior, Gimmestad noted how he had addressed both the co-pilot and the man on the ground with the intention of getting confirmation of his own interpretation of the situation. "I did not ask them the open question 'what do you think?' but rather sought support for the way I saw the situation. I said: 'it is probably a stain from other planes, don't you think?'." From his standpoint, the incident served as a reminder of how necessary it is to seek out and be open to other people's perspectives on the same situation (Gimmestad, 2016).

Fallibility is the tendency people have to make mistakes and errors, in the shape of small or large slips, mishaps, and blunders. Some of them can lead to serious harm, while others can create breakthroughs in experimental processes. One particular mistake can thus be the source of harm and frustration, while another can give cause to rejoice, even for the person who made it. The purpose of this book is to explore how the handling of fallibility affects the quality of what people try to achieve together at work. My motivation for doing research in this field is a curiosity about how human beings cope with fallibility at work, both on individual, group, and organizational levels.

The book builds on interviews with professionals from a variety of fields, including healthcare, aviation, public governance, engineering, waste management, and education. I have conducted (1) initial interviews and conversations with them, (2) written down their statements and made preliminary interpretations based on theory, and then (3) sent the texts to the informant to get his or her feedback, (4) written new versions based on that input, and (5) got the informant to read and comment on that version, before (6) finalizing the text from the meetings with that particular informant. With some of the informants, the process of reaching out for narratives and interpreting them has gone on for several years, with others the process has taken three to four months.

I interpret the narratives about fallibility at work in the light of theoretical input from philosophy, psychology, and pedagogy, as these contribute to the understanding of organizational behavior. The discussion in this book is also relevant for leadership theory and positive organizational scholarship. I find theoretical tools and resources in those

approaches, and build and expand on them. The book reaches out to fellow researchers who share my curiosity about fallibility dimensions of organizational behavior, and to practitioners in the fields where I have been doing my research, and more generally in organizations where it is important to cope with fallibility.

The narratives of fallibility that you find in this book vary in scale and scope. I interpret them as attempts to make meaningful connections between past, present, and future events. Narratives about change have previously been interpreted in the same manner (Rhodes, Pullen, & Clegg, 2010). At the core of a narrative about fallibility, we often find one critical event. A person appears to be making a mistake and it can set in motion a causal chain of events that either is stopped through human intervention, or develops into some dramatic outcome, either negative or positive. The term I will use for this kind of event is a *critical quality moment*, since the response or lack of it to the initial act will determine the quality of the work or outcome that emerges. The narrative about that moment can then focus on (i) what happened ahead of it, (ii) the moment itself, or on (iii) what takes place afterward.

In the narrative about the pilot and the driver of the pushback tractor, there is (i) an unmentioned past, which consists in a common history of being trained in Crew Resource Management (Gordon, Mendenhall, & O'Connor, 2012; Stoop & Kahan, 2005), a preparation method applied in aviation, (ii) the critical quality moment or event itself, where the driver decides to persistently challenge the pilot about the dripping, and (iii) a brief encounter after the event, where the pilot acknowledges the initiative from the driver. It is also a part of the aftermath that Gimmestad spread the word about the encounter, to further confirm and strengthen the existing communication climate of intervening across rank about serious incidents.

I have my academic training from philosophy, and the starting point for my reflections on fallibility at work is Socrates' motto "Know yourself". On the evidence of Plato's dialogues, where Socrates was the main protagonist, he dismissed the idea put forward by fellow Athenians that he was the wisest of men, and instead advocated the view that all human knowledge is fallible. None of his interlocutors in the dialogues

is able to convince him that they are any better, since their claims to wisdom do not hold up under critical scrutiny. Socrates, at least, admits that his beliefs about the world and society may turn out to be false, and so he may be the wisest, in the sense that he realizes the limitations in his own convictions and beliefs about the world (Plato, 1966).

There is a Socratic quality to the intervention from the pushback tractor driver at the airport, a willingness to challenge a person in power, in the name of doing things right together. He persists with his questioning even after he has experienced rejection and irritation from the higher ranked person on the receiving end of his messages. Socratic philosophy is practical at heart, both in the sense that it can address concrete questions about how one should act and live, here and now, and in the wider sense of being oriented toward the goal of leading a richer and better life. It rests on an assumption that an examination of personal beliefs, desires, and habits can lead to significant breakthroughs of knowledge regarding how to live a good life. You may come to realize that your current priorities and ways of living are not consistent with what you actually value and see as important, and so have reasons to make changes.

We can interpret "Know yourself" as a recommendation to look inwards, to examine one's own feelings, desires, commitments, preferences, and habits. Another interpretation of the Socratic motto is that the process of attaining self-knowledge requires you to look outwards, and take note of your own place and role in a community. Who are you among these people? How is your life and your aspirations connected to what other people are attempting to do in their lives? This relational dimension of being a person can be lost if Socrates' motto is understood solely as an exercise in inward meditation on what matters in one's own life. Self-examination in the Socratic sense can consist in an inward and an outward orientation. The former may be the one that springs to mind when we read the motto in isolation, but the latter discloses the social dependencies of human endeavors, and is essential in attempts to understand fallibility at work.

A Socratic examination of life at work can consist of asking questions that highlight relational and collaborative aspects: How is what you are trying to achieve at work dependent upon your colleagues' efforts? How

is what your colleagues are trying to achieve at work dependent upon your efforts? These questions address what Dutton (2003) has called high-quality connections at work. Recent research in organizational behavior documents the significance of helping and supportive behavior at work (Grant, 2014). Organizations differ in how employees perceive the threshold for asking for and offering help, and also in the degree to which employees and leaders alike hold back due to the apparent social cost of such activities (Lee, 2002; Wakefield, Hopkins, & Greenwood, 2014). To ask for help is to admit personal limitations, vulnerability, and dependence on others. The Socratic questions emphasize teamwork and collective effort, and can trigger a lowering of the threshold for reaching out to others, asking for help and offering it.

The book consists of seven chapters. Each of them addresses aspects of fallibility at work through the threefold temporal model of establishing connections between past, present, and future.

Chapter 1 focuses on childhood as preparation for adult life where fallibility is likely to be a significant feature. Research suggests that the extent to which children are allowed to engage in risky play will affect their ability to cope with adversity in adulthood. Protective parents and institutions can give priority to the children's safety, and restrict their scope of action in order to reduce the risk of harm. In doing so, the adults may also inhibit what has been called the anti-phobic effects of risky play, a process of releasing the children from phobias that have a significant purpose in early childhood, but will restrict them later in life (Sandseter & Kennair, 2011). The chapter explores the connections between childhood research and the concepts of (i) resilience, (ii) growth mindset and (iii) alternative self-understandings where people primarily see themselves either as agents or pawns, all of which are relevant in the context of coping with fallibility at work.

Chapter 2 discusses fallibility as a dimension of innovative processes. Leaders and organizations tend to assume that failure is always bad, and thus restrict experimentation that is required to learn and develop (Edmondson, 2011). The main narrative under scrutiny is about the decision to stop a large IT-project, despite the resources already invested in it. The principle of failing fast, of admitting that a particular idea or project is not as good as initially thought, makes theoretical and

practical sense, but is difficult to implement. The chapter introduces three obstacles to admitting defeat and stopping a project: (i) the sunk-cost fallacy, (ii) the bystander effect, and (iii) the confirmation fallacy. All of these are well-established concepts in explaining human irrationality, and here I apply them in the context of fallibility at work.

A nursing home is the setting for the narrative in Chap. 3. It explores a positive turnaround in that organization based on a raised level of activities involving the employees and residents. Kristine Borvik and Helén Norlin became leaders at the nursing home, and set out to respond to the old people's wish to come closer to life and not be isolated in their rooms. In doing so, they shifted emphasis from a proscriptive ethics (avoid harm) to a prescriptive ethics (do good). The chapter brings attention to the distinction between active mistakes (doing something you should not have done) and passive mistakes (not doing something you should have done), and how the latter appear to be tolerated more. It also discusses how perceptions of the extent to which one will have to take the burden for bad outcomes of one's own actions affect the readiness to take risks at work.

Chapter 4 investigates developments in aviation regarding fallibility, and builds on interviews with pilot Jarle Gimmestad and studies of relevant research. A barrier model for thinking about fallibility dominates the learning processes in this field (Reason, 1990). It distinguishes between actions and their outcomes, and how there is a need for a barrier system to stop the causal chain of events put in motion by a mistake. The obstacles discussed in Chap. 2 can help to highlight the weaknesses in the human dimension of a barrier system. Witnesses to a mistake may fail to intervene due to (i) sunk-cost bias, (ii) bystander effects, and (iii) confirmation fallacies. In addition, the tendency to tolerate passive mistakes more than active mistakes, described in the nursing home context of the previous chapter, poses a challenge to the reliability of the system.

The two main informants for Chap. 5 are experienced doctors, who convey narratives about coping with and learning from failure. Doctor Stian Westad encountered a situation where a mistake by his team led to the death of a baby. With the permission of the parents, he has shared the details of that tragic event with the author of this book, and in other

public settings. Doctor Bjørn Atle Bjørnbeth has established a biweekly complication meeting at the unit he leads, to talk about operations and treatments that have not gone as desired or expected. Both doctors focus on how failures and mistakes offer unique learning opportunities. The barrier system described in Chap. 4 is applicable to dramatic situations in healthcare, where a doctor or nurse may make a mistake, and human intervention can stop the causal chain it sets off toward a bad outcome. Trust is an overarching concept for explaining why it makes sense to work systematically to learn from failure in healthcare, since it is an expression of professionals' ability, benevolence, and integrity in relation to their patients.

A dramatic event in a river in Oslo is the starting point for Chap. 6, which addresses helping behavior as an integral dimension of coping with fallibility at work. A swimmer is stuck in the stream, but is reluctant to ask people on the shore for help. He behaves similarly to professionals who want do demonstrate independence and autonomy by performing their tasks without support from colleagues, even when they are struggling and unsure about the way forward. Research indicates that people tend to perceive requests for help to have a considerable social cost (Lee, 2002). Refusals to ask for and offer help at work can be systemic, and based on assumptions about what other people would be willing to do for you (Hämäläinen & Saarinen, 2007). In order to deal adequately with their own fallibility, professionals need to challenge such systems, and take the first steps needed to establish and normalize acts of helping at work.

The final chapter of the book provides the outline of an ethics of fallibility. It contains a normative and a descriptive dimension. The former addresses the extent to which honesty is the right response in situations where a person has made a mistake. Consequentialism and duty ethics offer conflicting advice to a decision-maker who can choose to own up to the mistake or keep it hidden. The latter dimension provides an explanation of what I will call moral fallibility, instances where a person acts contrary to his or her own moral convictions. Developments in moral psychology provide reasons to explain moral misconduct in terms of circumstances rather than character. We can combine the normative and descriptive dimensions of an ethics of fallibility in a stance

on the subject of forgiveness. Considerations of whether a person who has made a moral mistake ought to be forgiven (a normative issue) can be informed by knowledge about why people make such mistakes (a descriptive issue).

The threefold temporal model of thinking of fallibility in terms of past, present, and future appears throughout the book. The opening chapter emphasizes how experiences in childhood can serve as preparation for an adult working life involving critical events connected to one's own or colleagues' fallibility. The closing chapter is the most future oriented, since it discusses the extent to which people who have made mistakes deserve to start with a blank page and a new chance to do good work in the company of colleagues. The chapters in between all dwell on preparation, action, and retrospective learning in connection with critical quality moments, and conceptual input that can strengthen our abilities to cope with fallibility at work.

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