

Appendix: Blaming Workers for the Results of Mismanagement

"Employee error," increasingly, is scapegoated for whatever goes wrong in today's downsized, understaffed, sped-up workplace. Four items on the same theme:

1. SENATORS WERE WARNED OF LEXINGTON AIR CONTROLLER UNDERSTAFFING¹

JEFFREY MCMURRAY, ABC NEWS - Months before the Comair jet crash that killed 49 people, air traffic controllers at the Lexington airport wrote to federal officials complaining about a hostile working environment in the tower and short-staffing on the overnight shift, according to letters obtained by The Associated Press. In identical letters sent April 4 to Kentucky's senators, Republicans Mitch McConnell and Jim Bunning, a control tower worker said the overnight shift, or "mid," is staffed with two people "only when convenient to management."

The Federal Aviation Administration's guidelines called for two people to be there the morning of the Aug. 27 crash, but only one was present. "We had a controller retire last month and now we are back to single man mids," wrote Faron Collins, a union leader for the Lexington control tower workers. "I ask you one simple question. Are two people needed on the mids for safety or not? If they are, why are they not scheduled?" . . . Besides the letter to the senators, another Lexington control tower operator wrote to the FAA's Accountability Board on Dec. 1, 2005, complaining about a hostile work environment in the tower. That employee requested anonymity, fearing discipline against him.

2. Dian Hardison. "I F-ing Warned Them!"²

I told them that the technicians and engineers were overworked. I told them that there were too many managers and too many meetings and "dog-and-pony" shows. I told them that their senior "face time" play games, while they spent all their time plotting how to give each other pay raises, and left the guys on the floor to struggle day to day with obsolete and overpriced and unqualified equipment, was going to result in another Challenger.

¹ ABC News. <http://abcnews.go.com/US/wireStory?id=2427312&CMP=OTC-RSSFeeds0312> Link now dead. Originally linked in Progressive Review; quotes are from originally quoted text preserved in blog post: Kevin Carson, "Blaming Workers for the Results of Mismanagement," Mutualist Blog, Sept. 17, 2006. <http://mutualist.blogspot.com/2006/09/blaming-workers-for-results-of.html>

² Dian Hardison, "Shuttle Crash & Smug NASA Managers 'I F-ing Warned Them!'" *Counterpunch*, Feb. 1, 2003. <http://www.counterpunch.org/hardison02012003.html>

I was there for Challenger.

I saw the same exact conditions happening again. Overpaid, lazy, irresponsible managers concerned solely with their climbing up their ladders.

I told them they were skimping on inspections. I told them that the ground crews were asleep on their feet from exhaustion. I made as much noise as I knew how to make about the top-heavy bureaucracy sitting around in their fancy panelled offices, giving whorish press interviews in their smugness, while they did not have a clue what was going on in the real world where I was working....

Like Challenger, those who are most guilty are the ones who will attempt to make the most political capital out of it. But the blame for Columbia lies entirely and totally with the NASA administrators. They should all be investigated for their criminal negligence. They should all serve time in jail.

3. MSHA Makes The "Wrong Decision" To Blame Workers For Accidents³

That management likes to blame worker behavior for accidents will come as no surprise to American workers. That this "blame the worker" theory is not consistent with the facts, that it doesn't get to the root causes of workplace incidents is also not a surprise to American workers.

So this new Mine Safety and Health Administration program comes as a great surprise to all of us.

MSHA Launches New Safety and Health Initiative⁴

ARLINGTON, Va.- The U.S. Department of Labor's Mine Safety and Health Administration (MSHA) today launched "Make the Right Decision," a safety and health initiative that helps miners and mine operators focus on human factors, such as decision-making, when at work. The campaign encourages miners and mine management to work together on safety and health issues.

"MSHA will increase its focus on safety decisions during this campaign, which is not a limited-time initiative," said David G. Dye, deputy assistant secretary of labor for mine safety and health. "We want miners and management to make the right decisions to ensure the safety and health of America's miners."

So what's the problem with encouraging workers to make the right decision?

³ "MSHA Makes The 'Wrong Decision' To Blame Workers For Accidents," *Labor Blog*, July 28, 2005. <http://www.nathannewman.org/laborblog/archive/003252.shtml>

⁴ Department of Labor press release, "MSHA Launches New Safety and Health Initiative," July 13, 2005. <http://www.msha.gov/MEDIA/PRESS/2005/NR050713.asp>

First, the assumption of this program is that most accidents happen because workers make the wrong decisions. In other words, all you need is a little education, training and enlightenment and all will be well. If accidents continue to happen, they're caused by worker carelessness, incompetence, stupidity, suicidal tendencies -- and just plain dumb decisions.

In other words, "Make the Right Decision" is just your same old "behavioral safety" program under a new name. Behavioral safety theories say that worker carelessness or misconduct is the cause of most accidents, and disciplining workers is the answer. But behavioral theories don't hold up to a closer look at the root causes of most workplace accidents: generally management system and organizational problems that lead to unsafe conditions....

So what about these two "unavoidable accidents" reported last year? Would they be alive today if they had just made the right decision?

Two miners killed in pair of incidents

After badly burning his hands in a coal-mining accident earlier this year in Perry County, Edwin Pennington said he was finished with mining work, but he returned for the money, his father said yesterday.

On Wednesday night, Pennington, 25, of Harlan County, was crushed to death in a rock fall at a Bell County Coal Corp. mine — one of two underground mining deaths hours apart in Eastern Kentucky.

Eric Chaney, 26, of Pike County, was crushed in a roof collapse early yesterday at a Dags Branch Coal Corp. mine in Feds Creek in Pike County, officials said.

The deaths were the second and third fatal mining accidents in Kentucky this year, and the first underground fatalities. Nationally, 14 miners have died in accidents this year.

Bill Caylor, president of the Kentucky Coal Association, an industry group, said the two deaths were unavoidable accidents. "We don't want things like this to happen, but they will," Caylor said. "Mining is very safe, but you have to be careful because you're working around big pieces of equipment."

Or maybe Kevin Lupardus died because he made a bad decision:

Investigation of fatal accident at Boone mine continues

CHARLESTON, W.Va.- State and federal authorities are trying to determine what caused a section of high wall to fall onto an excavator at a Boone County surface mine, killing the machine's operator. The accident occurred at about 2 a.m. Saturday November 21, at Independence Coal's Red Cedar Surface Mine near Clothier. Independence Coal, a subsidiary of Richmond, Va.-based Massey Energy, operates the mine as Endurance Mining, according to federal Mine Safety and Health Administration records. Kevin Lee Lupardus, 41, of Mabscott, was operating the excavator when a "large section" of the highwall fell onto the machine's cab, said Terry Farley, an administrator with the state Office of Miners' Health Safety and Training.

It is somewhat ironic that this program is starting now. Clearly acting Assistant Secretary Dye hasn't read the June 2005 issue of *Occupational Health & Safety* which contains an article by Fred Manuele entitled "Serious Injury Prevention."

Manuele cites experts who point out that what may look like "human error" are actually system errors:

R. B. Whittingham, in his book *The Blame Machine: Why Human Error Causes Accidents*, describes how disasters and serious accidents result from recurring, but potentially avoidable, human errors. He shows that such errors are preventable because they result from defective systems within a company.

Whittingham identifies the common causes of human error and the typical system deficiencies that lead to those errors. They are principally organizational, cultural, and management system deficiencies. Whittingham says that in some organizations, a "blame culture" exists whereby the focus in incident investigation is on individual human error, and the corrective action is limited to that level. He writes: "Organizations, and sometimes whole industries, become unwilling to look too closely at the system faults which caused the error"

He notes that although humans may be involved in the errors that lead to accidents, James Reason and Alan Hobbs, in *Managing Maintenance Error: A Practical Guide* point out that one needs to look deeper:

Errors are consequences not just causes. They are shaped by local circumstances: by the task, the tools and equipment and the workplace in general. If we are to understand the significance of these factors, we have to stand back from what went on in the error maker's head and consider the nature of the system as a whole . . . this book has a constant theme . . . that situations and systems are easier to change than the human condition

In other words, look at the safety systems and find the root causes. If managers

(and MSHA) continue to attempt to prevent accidents by focusing on human errors and "wrong decisions," the same accidents, injuries and deaths will continue to happen.

4. Labor Relations in the Health Care Industry for Nurses⁵

More Nurses Needed

* **Understaffing:** There are not enough nurses to do what needs to be done on any given shift and the nurses who are on duty are exhausted and stressed. A 2003 study by the Institute of Medicine (IOM) found the environment in which nurses work a breeding ground for medical errors which will continue to threaten patient safety until substantially reformed. The IOM points to numerous studies showing that increased infections, bleeding and cardiac and respiratory failure are associated with inadequate numbers of nurses. A 2002 report by the Joint Commission on Accreditation of Healthcare Organizations called the nursing shortage "a prescription for danger" and found that a shortage of nurses contributed to nearly a quarter of the anticipated problems that result in death or injury to hospital patients.

* **Low Nurse-to-Patient Ratios:** With managed care restructuring the health care industry in the 1990s, hospitals reduced staffing levels to lower costs. Nurses care for more patients and patients who are more acutely ill due to shorter hospital stays. One study of hospital staffing found that decreases in the number of LPN/LVNs added to RNs' patient load. Studies have linked low nurse-to-patient ratios to medical errors and to poorer patient outcomes, as well as to nurses leaving patient care. A 2002 study by Linda Aiken, et al., found that for each additional patient over four in an RN's workload, the risk of death increases by 7% for hospital patients. Patients in hospitals with eight patients per nurse have a 31% higher risk of dying than those in hospitals with four patients per nurse. The IOM study recommends that nurse staffing levels be raised in all health care facilities.

* **Mandatory Overtime and Floating:** Because of the nursing shortage, many hospitals routinely require nurses to work unplanned or mandatory overtime and to "float" to departments outside their expertise. On average, RNs work 8.5 weeks of overtime per year according to a recent union survey. Mandatory overtime was an issue in several recent strikes and 77% of RNs favor a law banning it except when an emergency is declared.

* **Burnout:** Among nurses there are high rates of emotional exhaustion and job

⁵ Michigan State University, School of Labor and Industrial Relations, "Labor Relations in the Health Care Industry for Nurses: Online Credit Program," http://www.lir.msu.edu/distance_learning/MNAArticleandWebPage.htm

dissatisfaction which are strongly associated with inadequate staffing and low nurse-to-patient ratios. The Aiken study found each additional patient per nurse corresponds to a 23% increased risk of burnout, as well as a 15% increase in the risk of job dissatisfaction.

What's even worse, management's penny-wise, pound-foolish policies, which attempt to cut costs by deliberate understaffing, don't really even save money:

Statistical model shows [sic] that when nursing units are understaffed the additional costs associated with patients who develop complications are greater than the labor savings due to understaffing....

While immediate personnel costs are less with short staffing, long term costs were higher because patients with complications often stay longer in the hospital and require other expensive treatments....

Institutions attempting to decrease costs through health care worker reductions may, in the final analysis, incur higher costs as a result of higher rates of nosocomial infection, longer hospital stays and use of expensive antimicrobials and increased mortality.⁶

It's just another example of the MBA disease: stripping organizations of productive assets and milking them in order to inflate short-term returns.

By the way: the healthcare industry has its very own "behavioral safety" approach to hospital-acquired infections, directly analogous to the "human error" approach described above in the mining industry. The spread of MRSA and other infections in hospitals is the direct result of downsizing and understaffing--also the primary cause of patient falls, medication errors, wrong site surgery, etc., etc., etc., etc., ad nauseam. Healthcare workers know they need to wash their hands--but *knowing* and *being able to do* are two different things when the only orderly on the floor is literally running from one call light to another, and he's got three patients sitting on bedside commodes at the same time as two other fall-risk patients are setting off their bed alarms. Rather than deal with the root cause--the dangerous levels of understaffing that have resulted from the downsizings of the past decade--hospital administrators resort to asinine gimmicks like the "Partners in Your Care" program (designed by a manufacturer of hand disinfectants):

Patients and families are asked to be Partners in Your Care by asking all healthcare workers that have direct contact with their family member patient "Did

⁶ Wisconsin Federation of Nurses and Health Professionals, "A Summary of Recent Research Supporting the Need for Staffing Ratios and Workload Limitations in Healthcare." <http://www.wfnhp.org/setlimits/researchsummary.html> [Link no longer active, but available through Internet Archive]

You Wash Your Hands?" or "Did You Sanitize Your Hands?"⁷

Dilbert effectively parodied a similar program: the company response to on-the-job accidents was a "safety dog" who admonished "Woof, woof! Don't use scissors!"

Attempts to deal with safety issues through such behavioral approaches, rather than by addressing the structural and process causes, are what Peter Drucker called "management by drives" and Deming dismissed as "slogans, exhortations, and revival meetings." But in the modern workplace, such slogans and gimmicks are likely to appear on the very same bulletin board as quality jargon from Six Sigma or ISO-9000.

⁷ Official Steris corporate website. <http://www.steris.com/aic/partners.cfm>