Safety-Critical Systems in the Hands of Human Operators

An Introduction to the humandimensions of safety

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Agenda

- Introduction
- > The « Engineer view »
- Another Perspective on System Safety
 - Basic Assumptions on human activity in complex systems
 - A Study of 'automation' in Health-Care
- Conclusion
- Selected Bibliography



The Safest NPP is the one we haven't built. Safety & Productivity are two inseparable goals!







Wood's Anatomy for Disaster









A Common View on Safety

- Complex Systems are basically safe, and human errors make them unsafe,
- Human errors cause accidents
- « Failures come as unpleasant surprises. They are unexpected and do not belong in the system. » (Dekker, 2002)



Why not get rid of the pilot, then?



AWAYS TRUST YOUR INSTRUMENTS, SON.

Some Consequences

- There is a tendency to limit, to control human operation in the systems, through
 - An increasing number of procedures,
 - An increased level of automation
- A Decreasing number of opportunities for trial-and-error learning.

The Changing Roles of Human Operators

- From Operation to Supervision
 Pilot: an operator

 a navigator
 a symbol of responsibility
- "The ironies of automation"

What is wrong with this view?

Human Rationality

Humans are usually not stupid, but our rationality is bounded / contextual

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Another View on Safety

Systems are basically unsafe...
 ... and Human operators create safety everyday!



Accidents are « Normal »

- Perrow (1984) « Normal Accidents »: because we created systems that are both interactively complex and tightly coupled system accidents are normal!
- Roberts (1993): Some Organizations are so reliable that they operate safely despite interactive complexity and tight-coupling.

Basic Assumptions in order to understand human behavior

- > The 'Activity' always differs from the 'task'
- Our actions are always a trade-off between Efficiency and Thoroughness
- Work Practice is embedded
- We need to understanding learning processes





An Exemple (2/2)

QuickTime™ and a TIFF (LZW) decompressor are needed to see this picture.

Efficiency and Thoroughness

Embeddedness

- Physical Context,
- Social Context,
- Discursive Context,
- « Culture »

Cultural Context

QuickTime[™] and a TIFF (LZW) decompressor are needed to see this picture.

Studying Situated Learning

- Communities of Practice
- Openness of the tools

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Methodological Issues

- Ethnographically inspired methods,
 - Observations

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Research Questions

- How do nurses take care medications?
- What Makes this Activity Reliable?
- How does the new tool influence reliability? (in an idéal case!)

The Study...

- Pré-study: 4 clinics
- > 1 Clinic (medicine), 3 years after.
- Observations: « reactive » « nonobtrusive »
- Interviews

Results (1/3)

- Dispensation / Healing Process
- Activity characterized by constant interruptions (from different origins), in which nurses find support in different artifacts :
 - Different values of artifacts,
 - Relatively small place left to the IT tool.



Results (3/3)

- More than a simple change of support (not a surprise!)
- ▶ 1 Boundary-Object --> 2 objects
- New functions --> redistribution of power
- Is the round disappearing?

Implications for patient safety...

Improvement?

... surely

- BUT:
 - Some dangers are still present
 - Need to take into account the evolution of practice
 - Judicial frame needs to evolve?
 - Education
 - etc

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Designing for Safety

- > Systemic view of Safety:
 - M / T / O
 - Safety / unsafety is at the interaction!
- Adaptation through practice
- Reliability and Safety?
 - Unreliable systems create opportunities for learning,
 - Testing the frontier, the limits of operation

Selected Bibliography

- Perrow (1984) « Normal Accidents: Living with High-Risk Technologies »
- Hutchins (1995) « Cognition in the Wild »
- Nardi (1996) « Context and Consciousness: Activity Theory and Human-Computer Interaction »
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- Orr (1996) « Talking About Machines: An Ethnography of a Modern Job »
- Norman (1993) « Things that make us smart: Defending human attributes in the age of the machine»