The Application of Safety Ethics in Operationalizing Behavior Based Safety*

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Abstract

Applied ethics research shows that organizational climates and static, scripted decision making contribute to blind spots, which inhibit employees' ability to recognize that ethical dilemmas actually exist. These blind spots often result in disconnects between stated safety management goals and demonstrated business management practices. In other words, they contribute to a misalignment between the stated and enacted values of an organization, which in turn imposes upon the workforce a series of psychological, behavioural, and moral stressors.

This paper introduces two conceptual models to illustrate the untoward effects this misalignment of values has on worker motivation, social trust, and overall safety performance. First, the "Activity Trap," demonstrates how organizational stasis is due, in part, to an overemphasis on worker behavior to the exclusion of a more holistic account of how organizational behavior feeds into safety performance. Traditional safety management programs tend to focus on lagging indicators utilizing techniques such as gap analysis, benchmarking, and/or perception surveys. These techniques often cause a rush to address gaps and trends of individual and group behaviour, and are more often than not addressed by applying more antecedents in attempts to trigger behavioural change. This approach, however, often comes at the expense of a more nuanced analysis of how organizational behaviour actively influences worker consequence histories. We argue that this overemphasis on worker behaviour is largely underwritten by an entrenched imbalance between a process--- versus values---driven organizational culture.

When left unaddressed, the "Activity Trap" feeds into the "Safety Management Cycle." This second conceptual model details how worker behaviour is a composite of attempts to negotiate a cultural terrain of competing values exhibited in the gaps between stated organizational values and operationalized realities. Within this model, we characterize safety issues as moral dilemmas, and attendant decisions as requiring forms of ethical decision---making. Understanding the "Safety Management Cycle" and the role demonstrated business values play in safety outcomes allows us to expose and address the psychological and moral vulnerabilities created when these values do not align with the stated values of safety.

In order to operationalize behavior based safety programs and achieve sustainable change, organizations must be aware of, and effectively address the blind spots that occlude decision---making. Diagnosing and addressing these blind spots require a shift away from the traditional static accounting of worker behavior toward a more dynamic examination of organizational behavior. Part of this process entails taking an honest assessment of the ethical climate of our organizations, and taking stock of the (formal and informal) scripts that we routinely rely upon in our decision---making.

Keywords: Safety Ethics, Applied Ethics, Behavior Based Safety, Safety Culture

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Introduction

Implementing a behavioral based safety program has become readily accepted by many organizations as a way to increase compliance and improve overall safety performance. However, not all stakeholders are convinced. The United Steelworkers of America, for example, have taken a very firm stance against what they call "Blame the Worker" safety programs. (USW, 1998)

There is much research evidence and supporting statistics on both sides of the debate regarding the benefits and dangers of BBS, and the relationship between worker behaviour and hazardous conditions. On the one hand, opponents of BBS argue that it is most often the hazardous conditions workers are exposed to that are the root causes of the majority of incidents and injuries. On the other hand, proponents of BBS contend that the risks associated with any hazard are determined by the behaviors demonstrated in responding to the hazard. The reality is that both camps are correct.

The disconnect between truly successful BBS programs and the majority, those designed to check boxes and focus on worker behavior, rests not only in what we measure but how we measure. Utilizing decades of research and work with many of the world's leading corporations, Judy Agnew and Aubrey Daniels (2011) concluded that most companies focus too heavily on statistical outcomes and fail to utilize a scientific approach to managing safe and at---risk behaviours. They characterize the disconnect this way:

> *"Sophisticated companies that use only the latest scientific information and technologies from chemistry, physics, engineering, and biology, use so---called common sense, myth, and downright faulty information to manage the behaviour of their employees."*

Traditionally we focus on worker behavior by collecting data, often by applying consequences such as quotas or rewards to the workforce. This approach often encourages false reporting, creating the "safe by accident" phenomena. We then react to this often faulty data by developing antecedents, with an overemphasis on static processes, ignoring the scientific evidence that antecedents are responsible for less than 20 to 30 percent of behaviors. (Wilk Braksick L, 2007, et al) This overemphasis on antecedents overshadows the impact that consequences have on worker behaviour. These consequences and the worker histories they cumulate in are largely a product of organizational behaviours, both formal and informal. Nevertheless, the emphasis remains on directly modifying worker behaviour without addressing how organizational behaviour is feeding into it. In other words, by measuring the wrong thing the wrong way we create the perception, like that of the United Steelworkers, that management views the worker as the problem rather than part of the solution.

Terry McSween (2003) points to the challenge this creates when managerial (often static) processes destroy interpersonal relationships between the organization and the workforce.

> *"They* [management] *tend to resist innovation and typically will not champion proven but different methodologies, such as behavioral safety. Rather, they continue to plan training for toolbox safety meetings and revise safety awards while implementing yet a*

further variety of programs that rely on the use of posters, slogans, and other approaches of dubious effectiveness."

Leading literature on sustainable change indicates that a dynamic process in decision---making at the organizational level is required to achieve and sustain behavioral change at the worker level. (Kotter J., 2002, Kane W., 2008, et al) To truly operationalize behaviour safety programs we must first understand the root of these well---meaning but faulty static processes. This is where a safety ethics approach is required.

The Traditional Approach

Operationalizing any safety management initiative, including behavioral safety, requires much more than implementing a system or process. The truth is that, far too often, it is the way we implement programs that contribute to their failure. In their perspective on behavioral safety, the United Steelworkers of America draw a parallel to their history with total quality management systems. Historically, most, if not all, safety management initiatives are rolled out following the myth of Plan---Do---Check---Act. This is not to say that the concept is faulty but the methods used to put it into practice leads to the "flavor of the week" perception.

When organizations introduce new programs following the TQM model it is often in the form of a static management "Plan" to implement a behavior safety program. They then instruct the workforce to "Do" observations and record their findings on a card for trending. This is then followed by having someone from the management team "Check" for compliance (i.e., are they doing the observations?) and trend the behaviors reported. Finally, given the data collected they "Act" by rewarding (100% participation, most/best observations) or reacting (applying more antecedents to respond to negative outcomes).

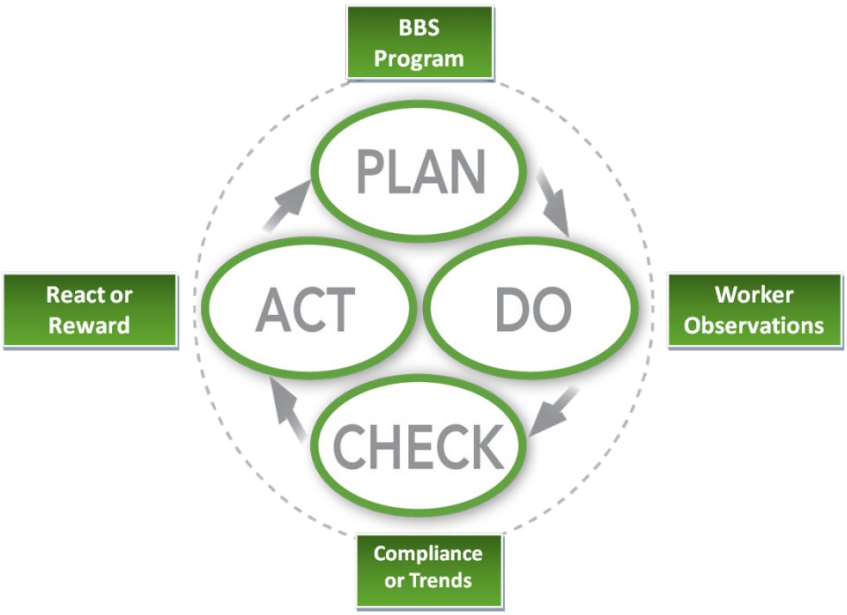

Figure A: *The Traditional Plan---Do---Check---Act applied to BBS*

In his book *Values---Based Safety Process --- Improving Your Culture with Behavior---Based Safety* (2003) Terry McSween explores culture as a "question of balance". Figure B below shows how he illustrates a simplified model of most organizations' culture and the two paths which require alignment to achieve and sustain the desired results (the Plan). Dr. McSween explains;

> *"In many cases, we train managers to manage by results, then, use antiquated systems of annual objectives and appraisals that maintain an unbalanced emphasis on results."* (McSween T. 2003)

Considering this within the Plan---Do---Check---Act loop, the results we are planning for is sustainable continuous improvement with our health and safety performance. Yet more often than not we check for compliance with the processes and fail to examine and diagnose the competing values within the working environment.

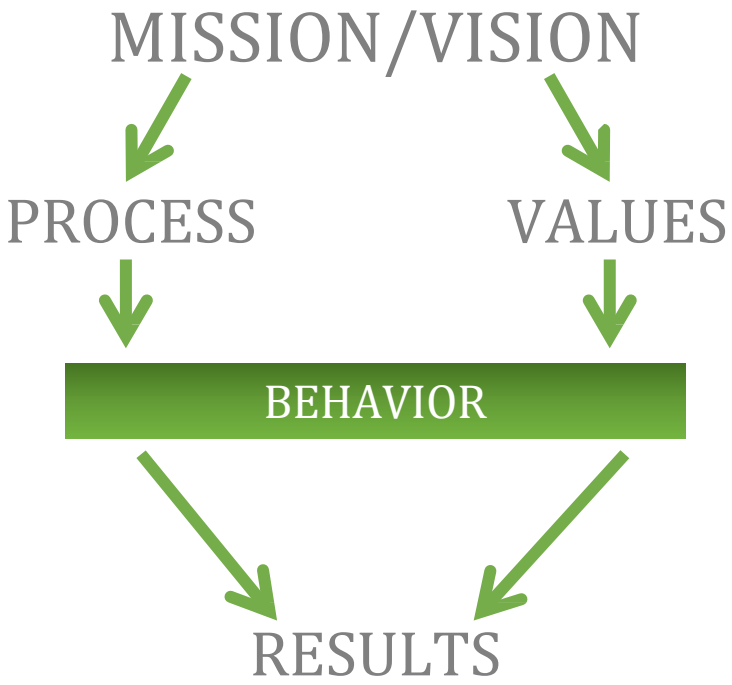

Figure B: *A simple model showing standard elements of organizational culture Source: Figure 3.1 Value---Based Safety Process, Improving Your Culture with Behavior---Based Safety, Second Edition, (McSween T. 2003) © John Wiley & Sons reprinted with author's permission.*

Behavioral psychology tells us that behavior is a function of the immediate environment and that all environmental events impacting behavior can be categorised as either an antecedent or a consequence. They further identify that consequences drive 70 to 80 percent of behaviors. Given this, in an environment where we traditionally manage by results driven processes, it is easy to fall into the belief that behavior based safety programs simply require us (the organization), to tell the workforce what we expect (the antecedent) and then react or reward appropriately (the consequence).

The above description, albeit simple, is most often the rule in organizations with reactive and/or dependent safety cultures. It is this methodology that fuels the perceptions and beliefs by behavior safety opponents, such as the HSE department of the United Steelworkers of America, that many organizations feel it is more effective to demand workers behave safely in hazardous conditions than it is to fix the hazards. This is not to say that BBS is faulty by design but rather to illustrate that simply implementing a BBS program focused on the process and results in and of itself creates a negative consequence history in the work environment. In other words, workers tend to feel that they are being held personally accountable, and are often blamed for unsafe practices when, in fact, they are somehow constrained or impeded by other situational and organizational factors in their efforts to act safely.

Terry McSween highlights the importance the work environment plays and the interaction between it and behavior.

> *"Unsafe work behavior is accordingly the result of (1) the physical environment, (2) The social environment, and (3) worker's experience with these."* (McSween T. 2003)

It is the worker's experience with the environments which must be examined to truly trend behavior. Simply stated, worker behavior is most often a product of organizational behavior, in the form of competing values between stated organizational values and operationalized realities, and the resulting consequence histories, good or bad. The effects of these organizational behaviors will be explored in more detail through the lens of applied safety ethics and the "Safety Management Cycle" in the section ahead, but, in order to truly understand the ethical issues we must understand the relationship of the "Activity Trap" and the process---behavior---results relationship.

The "Activity Trap"

Addressing the activity trap of traditional safety management requires all stakeholders to step outside their comfort zones and rethink long held beliefs and assumptions, another way of saying "*so---called common sense, myth, and downright faulty information"*. It is to this end that ethical based safety acts as an adjunct to behavior based safety creating values based safety.

Many behavioral science researchers have held to the belief that behaviors represent values bubbling to the surface. Likewise, a common held belief is that safety culture can be characterized as the way in which a given group will act in a given situation.

Regardless of whether we agree or disagree with the above definitions they do help to demonstrate a common challenge with our traditional approach to behavior based safety. We do worker observations and check the inputs for compliance and trends and we then act by applying antecedents in the form of safety campaigns and tool box topics and/or we apply consequences in the form of rewards for compliance or punishment (usually in the form of antecedents such as quotas or consequences such as loss of reward). We then sit back and either question why our process isn't achieving the planned result or, worse, we celebrate our success based on lagging indicators forgetting that this entire cycle sends a clear message that it is advantageous to the worker to not report (safe by accident).

This is not to say that behavior safety is inadequate in impacting continuous improvement outcomes but is rather to highlight that the methodologies deployed inevitably lead to a rules based reactive and dependent culture. This methodology can only clearly be addressed once we understand the activity trap and how we, as workers or organizations, fall into it.

Part of the challenge here is to stop short in our assumption that behaviors are simply a product of the if/then relationship between antecedents and consequence. While antecedents most certainly come before a behavior and consequences always follow a behavior as outlined in the A---B---C models often referenced in behavioral psychology there is another step most often over looked: "D" or the impact of the if/then relationship on *decision---making* based on the physical environment, the social environment and the workers experience or consequence history with them.

Our traditional approach of plan---do---check---act, when applied solely to workforce behaviors based on results driven processes, will always result in issues arising. It is interesting to observe how organizations around the world, regardless of their industry, appear to be in step with trends and challenges around issues such as trips---slips---falls, hand placement injuries, dropped objects campaigns or line of fire awareness programs, etc.

This phenomena is best explained referring back to the process---behavior---result model referenced previously. True sustainable change requires a dynamic approach in decision making both at the worker and organizational level. Processes, by their very nature, are static. Traditionally we implement a process, such as BBS, utilizing the plan---do---check---act model in the form of plan the process, do procedures, check for compliance and trends and finally act by rewarding or reacting to the results. These results represent the issues that almost always arise from the physical and social environments and decisions made based on this consequence history.

At the worker level these issues are driven by the many competing values such as the organization's stated values vs. their demonstrated values. It is the demonstrated values that define the organizational climate and create the social environment of the organization.

At the organizational level we focus on the issues as being a product of worker behavior and revert to past processes we are comfortable with, (safety campaigns, posters, rewards etc) all the while keeping to our tried and true TQM model of Plan---Do---Check---Act.

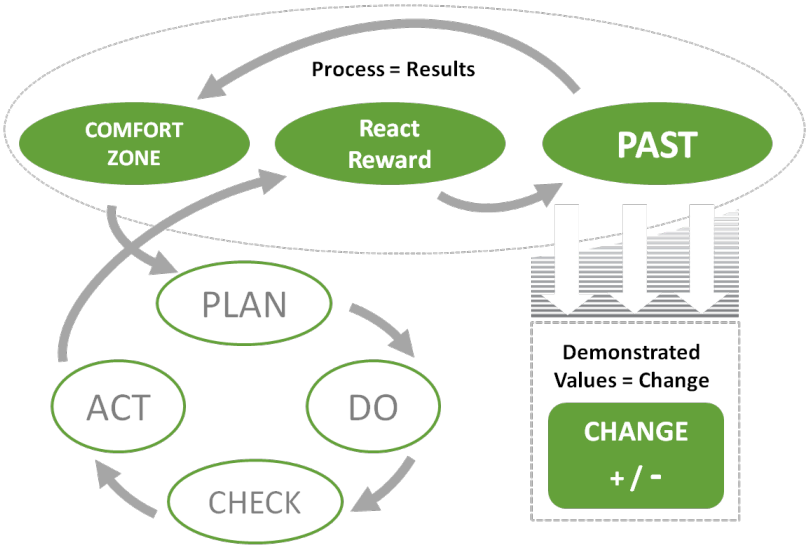

Figure C: *The Activity Trap ©Tri---Lens Safety 2013*

While there is proven benefit in worker led peer---to---peer behavior observation programs, the reality is that it is not enough to support sustainable change. At the floor level these programs, when introduced and administered properly, help to shape a social environment of trust, discretionary effort and a risk based interdependent culture. But this process must be supported by a dynamic system whereby the organization checks the data gathered from outside their comfort zone with a focus on organizational behavior and then acts by implementing the changes required to remove the barriers and consequence history. This shifts the focus off the static process driven worker behavior toward a dynamic values driven organizational behavior.

Moving any organization out of their static comfort zone is by no means an easy task. Easy is remaining in the comfort zone. Easy is static. Change is dynamic and sustaining change requires dynamic approaches. Sustainable worker behavior change requires social and physical environment change at the organizational level.

The Comfort Zone of the Activity Trap

Part of the reason organizations stay stuck in their process driven comfort zones is that processes are busy work. We feel like we're accomplishing things. We can codify them into policies and procedures, and they give us tangible results, which we can measure by trending worker behavior. Yet values are also influencing results and they too can be measured by looking at worker behavior.

Nevertheless, most organizations continue to shy away from looking at values head on. They might address them in round about ways, through establishing codes of ethics or values statements, but they fail to take a real look at how they are actually functioning in their organizations. Why? Because taking an honest account of the role our formal and informal values are actually playing means we're going to have to dive into some uncomfortable conversations at the organizational level --- conversations that are often difficult and unsettling in their effects.

Furthermore, most organizations are simply not equipped with the skills to facilitate these sorts of discussions and rely on safety management practitioners who are schooled in the results driven processes that create the comfort zones. However, if what we are aiming for is sustainable step change, despite the discomfort, values will have to be addressed.

Implementing a safety ethics approach is a critical step towards providing the tools for organizations to facilitate this sort of dialogue, and hold a space for the discomfort. These tools allow us to both qualify and quantify the "blind spots" keeping organizations stuck in the activity trap. Understanding the safety management cycle created by the activity trap allows us to move past what needs to be changed and focus on the why it needs to change.

By moving beyond the results driven, process oriented comfort zones and addressing the competing values impacting worker behavior organizations begin to unearth a great deal of potential for positive, manageable and sustainable change.

Safety Ethics and Values Based Safety

Values are the stuff that ethics is made of, and therefore integrating a safety ethics approach to safety management systems enables organizations to restore the balance between process and values driven results. Safety ethics provides organizations with the tools to facilitate conversations outside the comfort zone. It creates a safe space in which to identify blind spots created by the activity trap and reflect upon the discomfort of breaking out of the comfort zone. Safety ethics also provides us with a framework to begin diagnosing the ethical climates of our organization.

Performing this sort of assessment is a necessary task because part of the missing link, and the link we suggest is responsible for the current plateaus in safety performance, is that the ethical climates of organizations are not being addressed. The disconnects between an organization's processes and worker behavior often lies in the inconsistencies between the organization's formal and informal values.

> *"All too often discrepancies exist between the typical mission statement issued by organizations which state that safety is a top priority' and senior management actions."* (Cooper D., 1995)

For example, while "safety first" might be the stated formal value of an organization, in actual practice competing values, such a money, time and production, will seem to take priority. It's these competing values that largely influence decisions being made on the floor. Part of the shift that needs to happen is to begin directing attention towards *organizational behavior* in order to understand the root causes driving *worker behavior*. Shifting our focus to the level of the organization provides us with a more comprehensive picture of how the system as a whole is functioning, and with that in hand we can begin to parse out why behavior based safety is somewhat stuck in reaching the next level of safety performance.

The activity trap demonstrates how organizations remain stuck in a process driven results oriented culture. Safety ethics provides organizations with the tools to understand the climate fueling their culture from the values side. Without this perspective organizations remain stuck in their comfort

zones and will not break through the performance improvement plateau and consequently remain safe by accident. In the absence of a more comprehensive perspective, organizations will not fully understand the impact they are having on the workforce and how organizational behavior is feeding into worker behavior. This is where the safety management cycle comes in. The safety management cycle details how worker behaviour is a composite of attempts to negotiate a cultural terrain of competing values exhibited in the gaps between stated organizational values and operationalized realities. Within this model, we characterize safety issues as moral dilemmas, and attendant decisions as requiring forms of ethical decision---making. Understanding the "Safety Management Cycle" and the role demonstrated business values play in safety outcomes allows us to expose and address the psychological and moral vulnerabilities created when these values do not align with the stated values of safety.

Safety Ethics and Diagnosing the "Safety Management Cycle"

As Terry McSween (2003) points out, the first step in implementing a BBS program is to develop a *values or mission statement*. The mission statement functions as an antecedent meant to trigger the desired behaviors. An organization may develop a mission statement that says, for example, "We will be world class in safety." This acts as the stated value of the organization and is the starting point of the *Safety Management Cycle*. (Figure D)

When taken to the workforce, the first thing this statement does is create *awareness*. Even if workers do not unilaterally believe that the statement will be backed by organizational support, they are, at the very least, made aware that there is a live choice to be made. For example, do I report this hazardous condition? Do I stop unsafe work even though this means production will have to stop? The choice is a live one because there is some sense that the organization will back the worker should he or she make efforts towards fulfilling the mission statement.

In theory, the stated value is intended to create a shared value or compelling purpose. But as Yvonne Thompson (2010) states:

> "Developing a compelling purpose is a process that explores what's meaningful to the employees".

In practice, however, when organizations are focused on the process driven plan---do---check---act model and are stuck in the "activity trap," the worker has very little, if any, input into the "Plan" or the development of the mission statement. In most cases the stated values of the company, or of those involved in the planning, is not aligned with that of the workforce. In these cases the mission statements become nothing more than an attempt to shape behaviors with a well---meaning but disconnected antecedent because the workforce has not been actively engaged in developing the policies and procedures that stem from it. In other words, it isn't something they are personally invested in. Yet it is precisely this sort of involvement in all stages of development that is essential for fostering trust and establishing networks of interdependent relationships that are the foundation of any genuinely successful safety management system. The disconnects that are created when the workforce is not engaged in the process feeds into the *"Safety Management Cycle,"*

which, as the conceptual model illustrates, undermines even the best intentioned mission statements and attendant programs (Figure D)

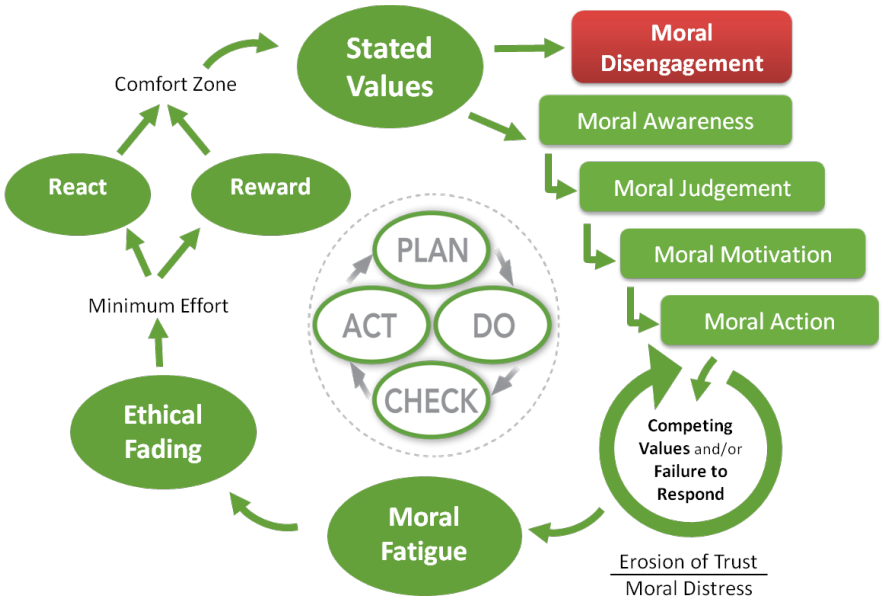

Figure D: *The Safety Management Cycle ©Tri---Lens Safety 2013*

When organizations rely on disconnected antecedents as their focal point for rolling out any safety initiative we generally see one of two responses. On the one hand, young, and new workers will typically take the mission statement on with a great deal of zest. "Yes! Good! I like this! This is good for me!" Although the mission statement might not have engaged the workforce in its development, for younger employees with less experience with an organization, the disconnect may not be as noticeable or is less tangible because they don't have an established consequence history with the organization. Entering into a new organization, they might be feeling excited and enthused about how the organization looks on paper and how they formally present themselves and pride themselves on their commitment to safety. On the other hand, more experienced workers, who have been with the organizational for a longer period of time, might be more skeptical: "Okay. I've heard this before. Show me you're actually going to back this up this time." Either way, this rollout creates an awareness, which in turn prompts *judgments* within the workforce regarding the validity of the mission statement and the organization's integrity in backing it up.

These judgments are largely informed by their individual consequence histories. In many cases, more experienced workers will have seen this before. They will have seen mission statements rolled out a number of different times, in a number of different ways, under a number of different names. Yet despite past discretionary efforts on their part and despite the stated goals of the organization, they have not been supported, nor have they seen results, or the results have been negative or inconsistent with the alleged mission statement. This is their consequence history, and it is a negative one. The judgments they form are largely derivative of these consequences histories, which in turn influence their individual forms and levels of *motivation*.

These variances in motivation are often exhibited through one of two responses. For example, new workers, with little organizational history to base their judgments on, are likely to be motivated by the antecedent. They believe the mission statement. This is good for them. They believe the mission statement will be supported by the organization. On the other hand, the more experienced workers, those with a negative consequence history, will remain skeptical. These workers are most likely to be motivated because they have to do it. They need to comply with policies and procedures. In essence, their motivation is to avoid being punished. In either case it is this motivation that drives the *moral action*, and largely guides the form these actions take.

Following the rollout of the program those who are skeptical are watching the organization's behavior. They may be thinking, "Okay, let's try this. Let's see what happens." Those that have already bought in and want to do it take action and begin to implement the processes with vigor and enthusiasm. Eventually, however, competing values start bubbling to the surface, and these new workers start to realize, "Wait a second, I'm getting conflicting stories about time, money, and production," or "I'm putting in all these observations, but nothing's really changing for me. The company is saying 'We're going to be world---class in safety,' but I've got all this other stuff that seems to be taking priority." They are faced with competing values that are often difficult to recognize in a process driven environment, creating dilemmas that don't get addressed or resolved. In these sorts of climates the motivated workers seldom receive positive feedback or support from the organization or their less motivated peers. Over time, this establishes a negative consequence history for the less experienced workforce, which is not easily undone unless directly addressed in the future. Thus, if left unattended to, regardless of what the new worker's judgments and motivation looked like when the program was rolled out and the mission statement originally issued, an *erosion of trust* in the integrity of the organization begins to occur.

This erosion of trust, however, is not solely the product of the direct responses the individual receives from his or her leaders. There are other factors influencing the novice worker's trust in the organization beyond their direct relationship with its leaders. As part of an organization, the individual worker is embedded within a larger network of relationships that constitute the situational context. Within this situational context there are a multitude of actors whose behaviors and attitudes constitute/teach/reveal/bespeak the hidden curriculum of the organization. This hidden curriculum is a composite of the informal rules and organizational norms that implicitly inform members of "the way things are done around here."

Think back to those young workers who bought into the mission statement straight away. They strive to implement the new program wholeheartedly. They start out motivated by discretionary efforts, and they want to see positive results and change. However, it is often the case that any rewards for these discretionary efforts are shared with those who demonstrate little or no efforts. This shows the novice that the consequences are inconsistent with the mission statement, i.e., "You tell me that we're going to be world class in safety, but the messages that I'm seeing don't match the antecedents that you've got up on the wall."

The skeptics, on the other hand, approach it halfheartedly demonstrating have---to efforts. Their consequence history tells them this is just another false alarm so they adapt by going through the motions because they have to. Yet they are seeing results. "I can fill out my observation cards in the

lunchroom. I can do this halfheartedly and I'm *still* going to get that jacket. I'm still going to get that cash bonus."

Through this entire process the motivated workers are watching the less motivated. What they see, and more importantly what they learn, is that those minimum efforts produce the same results and rewards as discretionary efforts. This hidden curriculum has a direct influence on the behavior of the new worker. If not addressed the motivated worker becomes the skeptical worker, the one with a negative consequence history.

Within this pocket of the safety management cycle, wherein trust begins to erode, it is the organization's behavior, their failure to respond to the new worker's discretionary efforts, which fuels this erosion of trust. It is this failure to respond that unwittingly supports the tainting effect of the more experienced workers' negative consequence history. When organizations get to this point and fail to address it, if they fail to recognize this loop, the skeptic's consequence history begins to taint that of the champion, and this is where the erosion of trust really begins to take hold.

This stage of erosion of trust within the safety management cycle is an organization's first opportunity to effect change. It is the starting point to begin asking the hard questions, to get out of their comfort zones, and identify the values they may be unknowingly demonstrating which are contributing to this tainting effect. It is a leading indicator which helps to identify when leadership may not be responding in ways that are consistent with their stated values. In effect, this cycle can be tied back to the mission statement. We know when we come back to reissue a mission statement and start this whole process again that this is going to be at play. We know the skeptics are out there. Thus before rallying the troops we first need to deal with that infection.

A safety ethics approach provides organizations a predictable measurement, which can be addressed at the rollout stage of any safety management initiative. This calls on organization's leadership to step outside of their comfort zones and deal with the negative consequence histories at play within the workforce. An important piece of this requires that we begin to change organizational behavior and address this misalignment of values. If we're process driven, however, we miss this opportunity, and in so doing we re---entrench this erosion of trust, advancing through the safety management cycle with further damaging effects.

This erosion of trust, if left unaddressed, leads to a form of *moral distress,* as workers must continually try to balance these seemingly incommensurable values. Their waning trust in the organization further exacerbates their distress because at the same time they are likely to begin questioning how their efforts are going to be responded to: whether their discretionary efforts are something for which they will be rewarded or whether in fact their efforts are something for which they might be (informally) punished.

Over time, this recurring feeling of moral distress leads to what applied ethics terms *moral fatigue.* Morally fatigued individuals are often thinking, "I want to do this. I truly want to do this, but no one's responding to my efforts. I'm seeing those around me being rewarded for just getting by, and I'm tired of exerting all this energy and dealing with the stress of it all." Moral fatigue is the impact over time of feeling morally distressed, and it has both personal and organizational consequences.

Moral fatigue, if not kept in check, moves into *ethical fading* – where the value of safety becomes neutralized. We no longer notice the ethical dimensions of acting safely because there are other competing factors – like money, time, production, or even holding onto your job. So the ethical dimensions begin to fade from view.

When the value of safety is neutralized, those workers who were keen in the beginning become the skeptical workers, discretionary efforts morph into have---to efforts, and mission statements start be seen as flavor of the day. Those workers who were skeptical to begin with weren't always that worker. When they first started, when they were first introduced, they took it on as champions. It is this erosion of trust, and this cycle of moral distress, fatigue and neutralization that creates those skeptics. Now we are in a position in which our antecedents, our mission statements, rather than moving skeptics to discretionary efforts, are actually moving our champions to have to efforts.

In the absence of discretionary efforts, we are thus led to a situation in which only the *minimum efforts* are being exhibited. The workforce is complying because they have to. They no longer champion it as their own because the ethical fading has taken out or neutralized the value of safety. They're just not seeing the support. These minimum efforts either lead to a critical incident that compels us to react, or the organization rewards outcomes based on *reported* lagging indicators, which may or may not be accurate. Either way, in the reacting or rewarding, we will often return to our comfort zones as we move forward, positioning us once again in the activity trap. In doing so, we continue to neglect our values, and how, if at all, we are demonstrating those values. We miss the opportunity to uncover how our competing values, for better or worse, are driving decision---making and end results.

Yet these competing values are truly the elephant in the room. They are always there and always looming large. We say safety first, but we know full well that, money, time and production are always going to be factors. The workers know it. The organizations know it. The activity trap of plan---do---check---act impedes organizations from dealing with this head on, and thinking about what this actually looks like in practice, and how they are going to address these competing values when they arise. Out of desperation, well---meaning safety practitioners return to their comfort zones of process driven results oriented safety management. Thus the real issues remain the unaddressed elephant in the room, and organizations continue to apply more antecedents, all the while failing to deal with the consequence history that they have created through saying this value, "safety first," and demonstrating something else.

Often organizations will react to less than favorable outcomes by suggesting that workers need a refresher course in soft skills around BBS. Following these soft skills training programs it is not uncommon to see workers leaving feeling invigorated and motivated. However, this is seldom, if ever, sustainable once they get back in the workplace. This is due, in part, to the organizational response to minimum efforts by restating values they have failed to demonstrate in the past. This renewed verbal commitment in response to the effects of the safety management cycle, while intended to motivate discretionary efforts among the workforce, actually creates a *morally disengaged* workforce.

This moral disengagement is a direct result of ethical fading, and when workers disengage they begin to turn off their usual ethical standards. This is to say that when workers are disengaged they shut off their own personal codes of ethics within the working environment. They are one person at home, in their communities, and with their families, and another person at work. "At home, I'm safe. I've got a family. I don't want to see them get hurt and I certainly don't want to model risky behaviors in front of them. But at work, it's another story". Thus with different roles come different sets of morals (i.e., role morality).

Given this, in order to manage or mitigate the cognitive dissonance created by not acting in accordance with their own personal code of ethics, the worker may begin to rationalize that the risk of getting hurt on site actually isn't all that great. Moral disengagement coupled with a neutralization of the value of safety in the workplace that makes this splitting possible.

Thus when organizations do these refresher courses or recommit to mission statements, when they put those antecedents to work, the moral awareness, judgment, and motivation are all impeded because the workforce has disengaged. The effect is going to be even less than it was the first time. When organizations fail to back up antecedents with a positive consequence history, renewing organizational commitments can actually be even more dangerous than not doing so, if the negative consequence history is not first addressed and these commitments are not actually put into action.

Behavioral Change

The goal of most behavior based safety programs is to change worker behavior. In our attempts to do so, we tend to stay focused on worker behavior because it is in our comfort zone. We think it's easy to measure. We can do statistics on it. We can trend it. However, in order to truly change those specific behaviors that are getting workers hurt, we need to get at the *organizational behavior* that's driving the worker's behaviors. The point here isn't that we stop looking at worker behavior. Rather, taking the lead from the United Steelworkers Union, we need to stop looking at worker behavior as the problem and start looking at it as part of the solution. It is part of the solution because it can lead us back to the gaps in the organization's value systems, and help us to pinpoint where trust has and is being eroded. Thus it's not that we don't want to look at worker behavior. We do. But in order to achieve sustainable step change, organizations need to spend less time looking at what and begin diagnosing why.

Throughout the *Safety Management Cycle* the issues confronting organizations are those of trust. When the cycle has gone full circle and these issues remain unaddressed the workers begin to migrate to the red and have disengaged. They don't trust the organization, the system, or the processes because the formal and informal values are inconsistent. And it is these informal values, this hidden curriculum, which largely contributes to workers' perceptions of "the way things are done around here," and what practices and processes are actually considered right and/or wrong. Eventually we end up in a situation in which, as Leslie Wilk Braksick (2007) puts it,

> "…workers are likely to claim that "The only sign around here we believe is the one that says WET PAINT."

This, in effect, means "We don't believe you. We don't trust you." It is this erosion or lack of trust that fuels the entire safety management cycle. From a safety ethics perspective, we've already discussed what organizations do to undermine it. In order to truly operationalize behavior based safety leaders must understand what trust actually is and what it looks like.

ORGANIZATIONAL BEHAVIOR, INTEGRITY AND WORKFORCE TRUST

By definition, extensions of trust always occur from positions that fall shy of probabilistic certitude. In other words, we can never be 100% certain. Trust always "leaps beyond the evidence" at hand. There's always some sort of vulnerability when we trust someone. When we do trust another, or we do trust our organizations, we risk disillusionment (because they don't live up to their mission statements), we risk being exploited (because we go above and beyond in our discretionary efforts with little or no recognition for doing so) or we risk being betrayed (for example, we risk being let go, fired, or marginalized from our work group because of our efforts). Because of this, trust is fragile and can only be broken so many times.

In many ways, trust is like health, or like air. We often only notice them in their absence, or when they become scarce or polluted (Baier 1994, 99). This simple point illustrates the difference between new and experienced workers. On the one hand, new employees will often freely extend their trust in an organization's mission statements. Their trust hasn't yet been tainted. On the other hand, trust is often scarce for more experienced workers, because it's been polluted by their negative consequence history with an organization. When trust does become scarce or polluted it is not easily regained, because just as I can't simply will myself to believe something, I can't simply will myself to trust another. I can rationalize why I ought to trust my organization (for example, it's in their best interests to be safe) but in spite of these efforts I might nevertheless remain skeptical. Nor can I trust you simply because you tell me to do so. Trust, like a belief, is something cultivated over time. It requires consistency and integrity on the part of the trusted.

How do we as an organization get to this consistency? How can safety ethics help us bring our values into alignment?

A safety ethics approach encourages us to step out of our comfort zones, and start asking ourselves some hard questions. Following Max Bazerman and Ann Tenbrunsel (2011), we might, for example, begin by asking: regardless of what formal policies and mission statements profess, who, in practice, is actually rewarded in our organization? What sort of person advances? How are unethical behaviors dealt with? How are they talked about?

The answers to these sorts of questions can help organizations to begin formulating an honest account of their informal values, and help them diagnose the extent to which they align themselves with their formal stated values, and the extent to which they undermine them. This can, however, be discomforting. As Bazerman and Tenbrunsel (2011) suggest,

> "Identifying the informal values that drive an organization is difficult and may reveal unpleasant truths, yet organizations that truly desire meaningful change must undertake this hard work."

Another piece of this work is to begin introducing ethical decision---making into daily organizational practices. This helps keep organizations out of the comfort zones where "business as usual" decisions tend to occur, those very sorts of decisions that reinforce and broaden the gaps between our formal and informal values, and the gaps between our actual safety outcomes and our ideal targets and goals.

When safety is a matter of good ethics, where there is a strong alignment between formal and informal values, where workers feel they can trust in the integrity of their organizations, they are more committed and are given traction in their capacity to act safely.

Integrating a safety ethics model into BBS systems helps to reconfigure the balance between processes and values. It provides us with some structured guidance on how to confront and work our ways through the inevitable messiness of directly addressing the elephant in the room. The rewards of doing so make having these difficult conversations worthwhile, because if we truly commit to the process, the levels of openness, honesty and vulnerability required have profound effects on our willingness to leap beyond the evidence at hand, and, once again extend our trust. This trust is foundational to the development and strength of the relational interdependencies of an organization. And it is the structural integrity of these interdependencies, these relationships, which enable us to operationalize our core values, and create sustainable step change in safety performance.

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