

EXPANDING LEADERSHIP

The Courage to Go Beyond Unsubstantiated Beliefs

By Robert Pater

How can you quickly increase your leadership effectiveness? If you've read any of my articles or heard me present, you might glean that I see arrogance as among the most prevalent fatal flaws in leadership.

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In large part, this is because arrogance is blind and reality has a way of reciprocating, blindsiding those who think they always know best. (Those familiar with the Dunning-Kruger effect may know this as the less a person's knowledge or ability, the greater s/he thinks it is due to an overload of false self-confidence melded with a deficit of critical thinking.)

Of course, arrogance can show in many forms, most of which are glaring and easy to spot: false pride, superciliousness, lording over others, disdain, being overbearing, pretentiousness, micromanaging, self-importance, blustering, conceitedness, being a poseur, imperiousness or being uppity. But it often boils down to a self-satisfied peacock strut: someone thinking and conveying that s/he is smarter than others or, worse, infallible. However, no one knows all in a world that is both overflowing with ever-fissioning data and constantly changing. Nor can any one person do everything. And none of us is immune to making mistakes.

But there is also a less-obvious, low-key and often below-the-radar kind of arrogance whereby a leader unquestioningly assumes his/her beliefs are correct without self-examination. This is the antithesis of mindfulness (whose theme might be "What's happening now?"). My colleague, Ron Bowles, refers to this as the arrogance of entrenched opinions and habits. Yet, even smart, highly skilled and trained professionals can get caught up in this self-imposed blindness (and perhaps some highly educated or experienced professionals may be more susceptible due to their overreliance on assumed previous expertise or preparation).

For example, Epstein (2017) strongly contends that U.S. physicians tend to be quick to adopt new procedures whether they work well or not, yet slow to abandon those that are actually proven to be ineffective; some protocols and procedures even create more harm. For just one, Epstein cites cases in which stents have been inserted to prevent cardiovascular related fatalities:

In 2012, Brown had coauthored a paper that examined every randomized clinical trial that compared stent implantation with more conservative forms of treatment, and he found that stents for stable patients prevent zero heart attacks and extend the lives of patients a grand total of not at all. In general, Brown says, "nobody that's not having a heart attack needs a stent." (Brown added that stents may improve chest pain in some patients, albeit fleetingly.) Nonetheless, hundreds of thousands of stable patients receive stents annually, and one in 50 will suffer a serious complication or die as a result of the implantation procedure.

And that's not just one outlying procedure; Epstein (2017) notes many more. For example, "CPR is no more effective with rescue breathing than if chest compressions are used alone; and breast-cancer survivors who are told not to lift weights with swollen limbs actually should lift weights, because it improves their symptoms." Or about atenolol, a highly prescribed beta-blocker for lowering hypertension (high blood pressure):

A 2004 analysis of clinical trials—including eight randomized controlled trials comprising more than 24,000 patients—concluded that atenolol did not reduce heart attacks or deaths compared with using no treatment whatsoever; patients on atenolol just had better blood-pressure numbers when they died. (Epstein, 2017)

This is astounding; clearly an instance where the monitored leading indicator (i.e., lower blood pressure) did not lead to the desired trailing indicator/outcome (i.e., fewer fatalities). The examples continue, even for musculoskeletal pain:

A procedure known as arthroscopic partial meniscectomy, or APM, accounts for roughly a half-million procedures per year at a cost of around \$4 billion. . . . This is not a fringe surgery; in recent years, it has been one of the most popular surgical procedures in the hemisphere. And a burgeoning body of evidence says that *it does not work for the most common varieties of knee pain* [emphasis added]. (Epstein, 2017)

Regarding surgery that is designed to (but frequently does not) repair (knee) meniscal tears, Epstein (2017) asks, "Why, when the highest level of evidence available contradicts a common practice, does little change?" Epstein's conclusion:

For all the truly wondrous developments of modern medicine—imaging technologies that enable precision surgery, routine organ transplants, care that transforms premature infants into perfectly healthy kids, and remarkable chemotherapy treatments, to name a few—it is distressingly ordinary for patients to get treatments that research has shown are ineffective or even dangerous.

Why Do Nonfunctional Beliefs Linger in Trained Professionals?

Many possible contributing factors may explain why nonfunctional beliefs linger in trained professionals. In the medical field, Epstein (2017) suggests:

Sometimes doctors simply haven't kept up with the science. Other times doctors know the state of play perfectly well but continue to deliver these treatments because it's profitable—or even because they're popular and patients demand them. Some procedures are implemented based on studies that did not prove whether they really worked in the first place. Others were initially supported by evidence but then were contradicted by better evidence, and yet these procedures have remained the standards of care for years, or decades.

But doctors are not the only professionals susceptible to dogged adherence to procedures that don't particularly work to an expected high level. This extends to the safety profession as well. Once admitted into the realm of what is acceptable, several approaches, tools and methods seem to linger on with a life of their own, disconnected from benefits that are purported but not actually realized (or whose payback occurred in the distant past and then diminished).

This is not the entire story. Sure, people get into a comfort zone, taking the same approaches time and again. But they also become mentally or emotionally attached to certain ways. Of course, there are reasons for this. Perhaps the approach some seem wedded to had previously shown positive results, so it was accorded a halo effect. Or they have been highly trained in an approach and feel themselves expert, so they default to going with their own perceived strengths or comfort zone. Or, they have other positive associations with it; knew, liked or respected a practitioner who led its charge; or think there's too much effort or time required to learn or bring in a different approach.

Have you read LinkedIn posts or letters from *PSJ* readers in which safety professionals adamantly defend certain practices, going far into the realm of emotional reactions that smack of "how dare you criticize this in any way!" past dispassionately discussing the strengths and limitations of an approach? Perhaps this reflects the human phenomenon of confirmation or other cognitive biases, whereby some identify so closely with an approach that they become less able to view it strategically, with both advantages and disadvantages?

It requires a high degree of mental leadership agility to be willing, be able and take the time to sort through the current strengths and limitations of any safety approach, tool or method. Note that in nature (both Mother and organizational), anything can and will deteriorate over time. Maintenance is always necessary to counter erosion; leaders must inject energy into both restimulating existing methods and doing periodic strategic assessments/reviews to determine whether these methods can still move people toward ever higher levels of safer perceptions, decisions and actions.

Holding on to unexamined beliefs that in turn don't hold water leads to diverting limited energy and resources, akin to "throwing good money after bad." These can block even considering, much less adopting, strategies that might actually be more effective than the "oldy-moldy" ones that leaders te-

naciously hold on to. Further, this mindset can also result in frittering away credibility when advertised expectations don't pan out, or just a perceived unwillingness to consider alternate methods and raise everyone's frustration (also true for communicated but unrealized more positive outcomes).

Taking a dispassionate look at one's own beliefs and commitments is easier to say or write than to do. But, as Abraham Lincoln remonstrated, "The dogmas of the quiet past are inadequate to the stormy present." It takes courage to coldly examine our beliefs, even in light of changing work or workforce, and to be willing to let go of those that no longer serve.

Nine Lingering Safety Beliefs: Do These Actually Work?

It's up to every safety leader to weigh the current merits of the methods s/he employs. I encourage each of us to not fall prey to the complacency we want to guard against in others. At the very least, I strongly recommend that as leaders we continue to reassess the value of the safety leadership approaches we perpetuate.

Following are several well-known safety methods to consider. My personal self-monitoring challenge: If I find myself becoming torqued up or defensive at someone questioning something I've done, I try to calm down and take a closer look at it. I believe that the more defensive I am, the more likely my judgments and leadership will suffer. Am I so doctrinaire that I bristle at the slightest suggestion of a weakness or concern with my preferred approach? Can I consider the downsides of something I believe in without emotionally responding to feeling personally attacked? These are questions I ask myself to help continue to raise my leadership bar.

Note that several of these nine beliefs are based on underlying assumptions that all leaders might question (some strategic, some technical).

Heinrich Pyramid to Reduce Serious Injuries & Fatalities

Heinrich's pyramid, modified by Frank Bird in 1969, focuses on reducing serious injuries and fatalities by reducing lower-level exposures. But there are at least two things we know: 1) Heinrich admitted that he did not base his findings on any valid research; and 2) his premise doesn't hold up, yet many professionals still allude to some version of this pyramid.

Quilley (2013) says, "Severity is not a function of repetitions in exposure." He contrasts dropping eggs with juggling chainsaws; while an incident of each counts as one, these two are certainly not comparable in risk and clearly don't lead to same number of serious injuries.

As Bowles, contends, "Getting one or more splinters in your hand doesn't necessarily have a lot to do with your risk of a fatal injury."

Incentives to Prevent Injuries

Based on behavioral conditioning, reward approaches continue to be promoted and sold to many companies. But these, too, can backfire. As Bowles says, "Incentives may serve to increase awareness temporarily, but also can reduce reporting, especially group incentives where

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an employee runs the risk of costing their entire work group to lose out on a reward.”

We’ve seen incentives de-incentivize workers; people become used to being “bought off,” where it takes increasingly high levels of giveaways to get their attention, while injuries continue. Plus, external incentives are at odds with internalizing safety, a hallmark of highest-level cultures, in which people want to and are personally motivated from within to recall, watch, retrieve and apply best safety methods even when no one is watching.

Time and again, the most effective rewards are not tangible but personal: recognition, sincere appreciation, even opportunities to help work through ongoing safety problems and make a real difference in their own and others’ lives.

Coefficient of Friction Measurements as the Main Way to Prevent Slips, Trips & Falls

Having worked in the slip, trip and fall prevention for more than 3 decades, I found that slippery surfaces don’t by themselves cause balance loss. Secondly, balance loss does not have to always result in an impact (fall). Have you ever lost friction while walking and skidded but didn’t fall? A combination of factors causes falls: 1) The upper body is not aligned over the lower body (leaning), combined with 2) momentum. This applies to both slips and trips.

Of course, a low coefficient of friction (COF)/slippery surface can certainly contribute to balance being compromised. But it is only one factor stirred into the same-level-fall-injury stew. What many companies have found is that mostly (or predominantly) focusing on COF achieves only a certain level of injury-prevention results (and does not port to falls on uncontrollable surfaces, such as outside, on others’ turf or at home). Too high a COF, especially when next to a much more slippery surface, can actually create trip hazards (as that first step can “grab” the sole of the foot), or a slip when first transitioning off it. [See “The ‘Surprising’ Realities of Slips, Trips and Falls” (Pater, 2017) or others cited for more details and proven prevention strategies including how, in certain cases, increasing COF can actually contribute to a fall.]

Back Belts

Back belts constitute yet another bandwagon that many jumped on, and some still ride. An oil company I worked with had given out lumbar support belts only to find lower back injuries increasing. I asked the safety leadership why they thought this was and what they were seeing. Most agreed that workers became complacent, believing that if they had their belts on, they could lift, push or pull loads, and were pretty much immune to getting hurt. This misplaced overconfidence was worse than mere complacency and is a type of arrogance that was sadly and mistakenly encouraged by the company.

Several types of such belts/supports exist. Depending on how they are used, some might have benefit. However, the problem here is less with the physical item than some leaders’ mental construct, hoping that handing out this equipment will be the (relatively cheap) magic cure for prevalent soft-tissue injuries.

Those with eyes wide open realize that strains and sprains (in fact, almost all injuries) have multiple contributors so that curtailing them will usually require more than a quick giveout. Be wary of any seeming quick fix; in almost all cases, “instant cures” often fall through and sometimes have negative side effects.

Stretching

Stretching has not been shown to prevent soft-tissue injuries, either among athletes such as runners or in the workforce. Yet many companies continue to initiate pre-work stretching programs (even inciting pushback from both bargaining units and nonunionized workforces). Hutchinson (2020) cites the 2018 edition of the Physical Activity Guidelines for Americans, from Department of Health and Human Services, which says, “Flexibility activities are an appropriate part of a physical activity program, even though their health benefits are unknown and it is unclear whether they reduce risk of injury.” Hutchinson writes, “Um . . . then why are we recommending them?” and, “being flexible doesn’t seem to protect you from injury. . . . There are a few [studies] that find that being too flexible is also associated with injury.”

Citing a 2007 study, Hutchinson (2020) says, “stretching before, during or after a workout doesn’t do anything to prevent subsequent muscle soreness. It doesn’t seem to reduce injury risk either.” Nor does it seem to increase longevity. [See “The Impact of Movement on Safety, Health and Longevity,” citing studies for correlations with living longer and safer (Pater, 2018a).]

And so on. That’s not to say there are no benefits to stretching; I’m aware of several possible. But assuming this is the direct key to preventing soft-tissue injuries is yet another case of an old paradigm that some have continued with little or no data that support it.

McKenzie Lifting Method

There is controversy over whether the McKenzie approach to lifting (lifting off of a lower surface by first deeply squatting, with bum out to emphasize spinal extension) is actually safer. A Danish study found that not only wasn’t there a link between lifting with back flexed (bent over forward) and pain, but the reverse: Workers who spent more time flexing forward more than 30° reported lower back pain levels (Villumsen, Samani, Jørgensen, et al., 2015).

But what I have seen in the real world of work, especially with aging workforces, which tend to be especially prone to soft-tissue injuries, is that this method assumes a high level of hip and knee flexibility that many never had or no longer have. What I’ve seen in practice is people starting to assume the position, then, due to limits from inflexibility or pain, bend over from the waist, which most would say actually increases stresses on the lower back.

NIOSH Lifting Equation as Main Way to Design Out Overexertion Injuries

The revised NIOSH (1994) lifting equation is just one of several lifting equations aimed at helping professionals design out loads that are unsafe/too heavy to lift. This equation has been modified several times, due to complexity of use and its underlying

assumptions that the lifters have basically similar physical characteristics. Of course, this is not so. And people can vary from day to day in their levels of readiness for doing heavier physical work.

Additionally, the revised NIOSH equation, while admittedly one of the most widely used worldwide, offers different results from many of the others. Russell, Winnemuller, Camp, et al. (2007), concluded:

The NIOSH, ACGIH TLV and Snook methods were similar in their results with respect to the pattern of exposure over various height levels and the differences in exposures associated with lifting 15 and 23 [liter] cases. However, the WA L&I and 3DSSPP predicted substantially lower exposures.

So, to minimize risk, which should one follow? My thought: These are only guides that are general in nature. Each exposure is unique to conditions and workforce. And this does not account for which training methods are also employed that may potentially lower (or not lower) risk of injury.

PPE for Those Who Don't Need It

Are you aware of companies that require “gate-to-gate” PPE, causing office staff to wear hearing protection when their measured work site decibel level is not in the danger zone? Other reasons may be behind this practice: Out of solidarity with those who actually have potentially damaging noise exposures; believing it's easier to administer an across-the-board policy; or perhaps because “rules are for everyone, no exception.” These kinds of policies erode safety credibility, making it less likely that leaders will be listened to when they surface actual risks (akin to the boy who cried wolf).

Trailing Indicators to Predict Future Performance

Consider that reliance on trailing indicators, which is common with many companies, typically assumes that past performance helps predict what will happen in the future if nothing changes. Of course, there is certainly value in this, but life is rarely a straight-line steady state. The past infrequently predicts the future (and this further assumes that trailing indicators such as lost time injury rates are reported accurately). Epstein (2019) debunks the ability of even noted scientific experts to predict what will happen in the near future.

Of course, what has previously occurred certainly has relevance to what might happen in the future. But leaders should be wary of tunnel-visioning into an all too prevalent lock-the-barn-door-after-the-horse-escapes mindset. That is, they should not become overly focused on fixing a disproportionately small-in-impact amount of problems while ignoring the mass of ongoing injury sources that persist.

Get Perspective

Clearly more assumptions than just these nine need examining. I invite you to comb through your ongoing scheduled beliefs, practices, methods and approaches to see if your company's safety defaults still hold water or whether they are just being repli-

cated for their own sake. Yes, it can be challenging to zoom in and out to see the forest and the trees, to get perspective on your organization's cultural beliefs. Sometimes, multiple viewpoints from internal colleagues or outsiders can help.

It takes courage to be willing to look at long-standing accepted beliefs, to consider whether they (still) hold true. Moving toward higher-level leadership means questioning what we've always been doing, melded with the inner strength to admit that it might be time to let go of old ways and try something different to step up safety performance and culture. **PSJ**

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