Reality Check: The Myth of Multitasking and Debunking The Blame Game

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Feedback from a reader of the NRMC's eNews reminded me of one theme in one of the most thought-provoking "books" currently residing on my electronic reading device. The book, by Joseph T. Hallinan is titled: *Why We Make Mistakes: How We Look Without Seeing, Forget Things in Seconds, and Are All Pretty Sure We Are Way Above Average.* Two of the subjects explored in this fascinating book are the "myth" of multitasking and the tendency to affix blame rather than determine the real cause of our mistakes. As I do in so many instances, I see very direct applicability of this exploration to risk management in nonprofit organizations.

Mythological Multitasking

Many of us believe, to a lesser and greater extent, that our brains are capable of multitasking or at least the credible appearance of multitasking. After repeated calls to an IT help desk where I was told that having dozens of software programs open at the same time was the likely cause of my PC's crash, I learned the hard lesson about computer multitasking. As it turns out, my top of the line PC is only doing ONE thing at a time. It switches between tasks so quickly that it appears to be multitasking. My attempts to make my PC operate more than a dozen software programs simultaneously may, and often does, cause the computer to trip and suspend some programs. In some cases the only way to recover is by shutting down the computer altogether.

According to Hallinan, studies demonstrate that the human brain is similarly limited: it can only handle one complex task at the same time. Hallinan admits that it is possible to walk and chew gum at the same time, but reminds us that chewing gum is not a complex task akin to "thinking." A colleague of mine (you know who you are…) takes advantage of the brain's inability to multi-task by always calling on the workshop attendee who is obviously engrossed in composing a message on his or her PDA. On several occasions I have been the deserving victim of his finely tuned skill of observation. When he asks, "Melanie, what are your thoughts on the subject?" all I can do is sheepishly request that he repeat the question.

Multitasking risks abound in nonprofit organizations. Examples include:

- **Permitting, or looking the other way, when drivers for our organizations engage in any activity other than focusing on the road, the vehicle and the route when driving on our behalf.** Although the most publicized stories focus on the risks of driving while texting or speaking on a mobile phone, there are less known studies that remind us of the danger of doing anything other than basic driving, including changing CDs, eating/drinking, chatting with or otherwise entertaining a passenger and personal grooming. Rather than overlooking this behavior, nonprofit leaders should make it clear that multitasking in a moving vehicle is forbidden.

- **Allowing a single individual, either a volunteer or employee, to wear two hats that create an easy to miss conflict of interest.** While conflicts of interest might not be per se a bad thing, the devil's in the detail of how an organization's leaders identify and manage conflicts. Unobserved and undisclosed conflicts cannot be managed to protect the organization's interests.
- **Doing more with less.** A common mantra in nonprofit organizations is the need to do "more with less." Let's face it, nonprofits are accustomed to receiving less than they need, and the knee jerk reaction of many leaders is to make do. Making do includes asking staff to work longer hours, serve a growing number of clients, and do it all while reducing expenses by 5, 10 or 20% in order to balance the budget. Few leaders make such requests (or demands) while also specifically acknowledging and anticipating the accompanying risk of reduced quality or the increased risk of error, even though these risks are real. While it is certainly possible to make thoughtful changes that increase productivity, simply doing more with less is an outdated theory rather than a practical strategy for ensuring high quality service. In the absence of such productivity-increasing strategies, enlightened leaders need to consider the need to do "less" with less and identify ways in which an organization can reduce or even eliminate programs and services that contribute minimally to the nonprofit's mission.

The Blame Game

Another theme in *Why We Make Mistakes* is the tendency toward blame. According to Hallinan, the vast majority of errors, from workplace accidents to airplane crashes, are quickly and almost universally attributed to human error. Blaming people, for whom making mistakes is arguably second nature, if not an element of the human condition, distracts us from the taking a closer look at mistakes and errors that occur in the life of the organization we serve. In some cases a closer look might reveal cultural, systemic, technological or process barriers that lead to human error.

The staff member whose work product contains typographical errors is likely to be blamed for sloppy work. Yet research shows that the human brain is wired to "skim" familiar territory, resulting in the ease with which misspelled words are overlooked by their author. You know what it is you intended to say and therefore your brain simply confirms those thoughts. Hallinan reminds us that "the better we are at something, the more likely we are to skim." This causes us to see familiar things (think processes in our organizations) not as they actually are, but as they ought to be. I have noticed this phenomenon in nonprofits when long time staff members report that policies are generally followed "to a T," while newer members of the management team are more likely to report deviations between policy and practice.

The downside of our inclination to skim is that when we skim we overlook often important details. Now, that's not to say that some writers are a bit more or less careful than others. Or that others are eager to divert blame to the incompetence of spell checking programs. An alternative to affixing blame on a human culprit is to look for ways to increase the likelihood that errors will be found before mistakes have real impact. In nonprofits where "incidents" are logged but follow-up action is limited to actual claims and losses, the organization misses an opportunity to uncover the real reasons behind near-misses and identify steps that might be taken to avoid the next near miss or actual loss.

The wisdom of Hallinan's book reminded me that the Center often assists nonprofit leaders in:

- **Cultivating a "culture of reflection" that insists on the careful review of accidents, errors and near-misses.** Remind yourself that blaming unwanted outcomes on human error does little to help an organization reduce the possibility that the same mistake will be repeated. It's neither practical nor productive to terminate every human being who makes a mistake. Developing policies and procedures that require an organization to look for the root causes of errors is more practical and affordable in the long term.
- **Looking for ways to simplify or clarify policies and procedures** with eye towards reducing accidental missteps as well as resistance. Don't fall into the trap of believing that enforceable policies must be wordy and bureaucratic. Rewrite and rework policies so they are most likely to be understood by newcomers and veterans alike.

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