# Pilot Performance During Multiple Failures: An Empirical Study of Different Warning Systems

Gideon Singer

Flight Operations, Saab Aircraft AB Linköping, Sweden

Sidney W. A. Dekker

Centre for Human Factors in Aviation Department of Mechanical Engineering Linköping Institute of Technology

Dynamic fault management—that is, dealing with a cascade of failures while maintaining process integrity—is a dominant human task in various transportation modes (e.g., commercial aviation, shipping). The way in which a warning system represents failures and the way in which the system contributes to failure management jointly determine the amount and kind of cognitive work in which the human has to engage to manage multiple failures. In this study pilot performance on 4 different commercial aviation warning systems was tested by measuring time and error rates in identifying root causes in a cascade of failures. All systems tested represent failures in the same basic way (a message list) but differ in the kind of contribution they make to the failure management task; for example, by sorting failures, prioritizing them, selecting only some failures for presentation, guiding the pilot on what to do next, or showing the pilot which systems are still operational. Human performance benefits accrued in systems that (a) provided guidance on what to do next and (b) showed which systems were still operational. These findings are consistent with the cognitive demands of dynamic fault management and carry important messages for how those demands should be supported. The results suggest that rather than automating even more of the human role in fault management to minimize error counts, attention should be paid to the kinds of referents and representations that are most useful in informing the operator of what is going on in the underlying process and how best to cope with it.

A dominant role of human operators in all modes of transportation today is to manage system failures. Faults in complex, dynamic systems typically propagate through physical as well as functional interdependencies, producing a cascade of disturbances and failures (Billings & Dekker, 1996; Woods, 1994). *Managing* these failures can mean anything from diagnosing, understanding, and resolving them; to sorting or prioritizing them; to merely containing or mitigating their consequences. Almost invariably, however, the identification of primary faults (setting off the cascade) is of critical importance. Two characteristics of a warning system jointly influence the human abil-

Requests for reprints should be sent to Sidney W. A. Dekker, Linköping Institute of Technology, Centre for Human Factors in Aviation, Department of Mechanical Engineering, SE-581 83, Linköping, Sweden. E-mail: sidd@ikp.liu.se

## 64 SINGER AND DEKKER

ity to manage multiple failures and recognize root causes that underlie the disturbance chain. They also determine the nature and amount of cognitive work in which the human has to engage when failures occur. These two characteristics are (a) how the system represents underlying failures and their interconnections on a warning display and (b) the extent to which the system itself contributes to the failure management task by sorting out, prioritizing, resolving, or containing the failure or by determining what is left operational and what to do next.

Incidents in commercial aviation and elsewhere keep stressing the need for better support during dynamic fault scenarios, especially in highly automated aircraft with multitudes of electronic interdependencies (e.g., Billings & Dekker, 1996). Studies about how to support the human in this situation are often limited to paper evaluations (e.g., Hicks & De Brito, 1998) that produce no performance data. The Federal Aviation Administration (FAA; 1996) encouraged further research into aircraft warning systems, because data on different kinds of systems are either unavailable or inconclusive. For example, in earlier knowledge elicitation (Mårtensson & Singer, 1998), pilots from a variety of backgrounds revealed ambiguous preferences relative to representational features of warning systems. They tended to dislike guidance on what to do next about failures that arise from within their aircraft—yet they indicated they were happy to accept guidance associated with warnings from the outside, for example, ground proximity warnings or traffic alerts. They also indicated that they wanted less on the display and more prioritizing done by the system but wanted to be kept fully in the loop on all malfunctions that have occurred and what, if anything, the system is doing in regard to them. This would seem to produce a collection of irreconcilable design requirements, which is one reason pilot opinions about system design are often treated with some suspicion by manufacturers and certifiers of systems alike (e.g., Courteney, 1999).

In this article we report empirical data on pilot performance with different kinds of warning systems that were modeled on four existing systems in commercial airliners flying today. These systems do not differ substantially with respect to their representational quality; that is, what they represent (aircraft subsystems and their status) and how they represent it (message lists containing abbreviations that point to some system and its status in some color) are essentially the same across different manufacturers. Where they differ is the extent to which the system itself contributes to the failure management task, and there are various ways and gradations in which manufacturers do this. Contributing to the failure management task can vary from prioritized or sorted presentation, to selective presentation, to presenting guidance on what to do next, to indicating which system or component is still operational. This allowed us to assess the effect of different ways in which systems themselves prioritize or otherwise deal with failures before representing them on a display.

## PROBLEM REPRESENTATION

A fundamental finding from cognitive science and related research is that the representation of a problem determines the kind of work in which the problem solver has to engage and influences the efficiency of the problem-solving process (Woods, 1995). As Simon (1969) put it, "Solving a problem simply means representing it so as to make the solution transparent" (p. 71). Parallel findings from studies of naturalistic decision making reflect how practitioners who are faced with complex, ill-structured problems make a considerable investment in making sense of the problem, in restructuring it, whereafter the decision (solution, really) becomes obvious (e.g., Klein, 1998). This means

that the representation of warnings goes deeper than superficial issues such as color, indentations, number of displayed lines, and so on. A critical aspect of representations—and how they help or hinder problem-solving performance—is the way in which differently coded symbols (words, lights, icons, colors, etc.) point to, or represent, referents in the underlying monitored process and whether the referents represented are of any meaning given the problem-solving task (Woods, 1995). Referents in today's warning systems are often single components or subsystems (e.g., LEFT GEN: the generator on the left side) and that component's or system's status (e.g., FAILED). The surface features of these referents are often the sole focus in design and evaluation discussions. Should this one be red or yellow? Should this be one indentation farther or not? How many warnings (referents) can we put on one page? Designers can get lost in the details of superficial features without making fundamental progress on the representational quality, that is: What actually are the referents of interest, and how do we represent those?

# DYNAMIC FAULT MANAGEMENT

In the language of the domain (in this case, aviation), warnings are often said to serve three purposes: to (a) *alert* the pilot that something is wrong, (b) *report* what is wrong, and (c) *guide* the pilot in what to do (Mårtensson & Singer, 1998). These straightforward-sounding purposes obscure a much more intricate cognitive reality that lies behind the management of multiple failures in a complex, ongoing, and changing process. What confronts problem solvers in dynamic domains is the need to diagnose malfunctions while maintaining process integrity. This is called *dynamic fault management*, a distributed human–machine activity that the field of human factors is only just beginning to appreciate (Woods, 1994). A fault in dynamic processes typically produces a cascade of disturbances or failures. Both functional and physical fault propagation are normal features of modern airline transports, given intersystem couplings and how tightly systems are packed together physically (Billings, 1996; Billings & Dekker, 1996; Hicks & De Brito, 1998). Not only must failures be managed while keeping the aircraft flying but also their implications for the ability to keep the aircraft flying in the first place need to be understood and acted on. Keeping the process intact and diagnosing failures are interwoven cognitive demands in which timely understanding and intervention are often crucial.

Given system cross-couplings in modern airliners and the dual demands of dynamic fault management, things other than the status of single components or systems may be more interesting for a pilot to derive from his representation of failures. For example, what are the interconnections between the multiple failures (what is the structure of the problem so that a solution or countermeasure becomes evident)? Given the phase of flight, what issue should be addressed first? What are the postconditions of these failures for the remainder of operations (i.e., what is still operational, how far can I go, what do I need to reconfigure)? Is there any trend? Are there noteworthy events and changes in the monitored process right now? Will any of this get worse?

Current warning systems in commercial aircraft do not go far in answering these questions, something that is confirmed by pilots' assessments of these systems. For example, pilots have commented on too much data, particularly all kinds of secondary and tertiary failures, with no logical order, and primary faults (root causes) that are rarely, if ever, highlighted (Mårtensson & Singer, 1998). The representational nature is limited to message lists, something that is known to hamper operators' visualization of the state of their system during dynamic failure scenarios (see Potter & Woods, 1991, who also recommended showing guidance to the operator on what to do next).

#### SUPPORTING THE FAILURE MANAGEMENT TASK

Warning systems today, although similar in their representational quality, differ in the extent to which they contribute to the failure management task. The growth in computational power has allowed designers to automate more and more in managing system failures, and in the field of commercial aviation different manufacturers have pursued different philosophies in what and how much should be left for the human (Billings, 1996; Hicks & De Brito, 1998). The contribution of the system to failure management ranges from prioritizing or sorting the failures, to selecting some for presentation, to providing guidance on what to do next, to presenting what system or component is left operational. Systems that sort and prioritize failures and leave out clutter can make the structure of the problem clearer (Klein, 1998), thus supporting failure management by helping the human make quicker assessments about what may be the root cause. But managing failures in complex, dynamic settings goes beyond just diagnosing failures or their root cause(s) individually. It also includes understanding the operational implications of failures, that is, understanding how failures threaten system integrity or operational continuity. Some warning systems seem to cater more to this understanding than others do. So, given static representational quality across the different manufacturers, the way in which a system contributes to failure management could carry consequences for human performance in dynamic fault management. This is what we tested in this study.

# FOUR DIFFERENT WARNING SYSTEMS

The study reported here was intended to generate empirical data on pilot performance with different warning systems. Given static representational quality, existing systems show a gradient in how they support the human in managing failures and understanding their implications. Today's systems range from contributing almost nothing to doing almost everything in terms of failure management. In between, systems typically try to support the pilot by sorting through the multiple failures and prioritizing them (which can reveal the nature of interdependencies; e.g., by recognizing root causes) and by guiding the pilot on what to do next. In existing warning systems available from commercial aircraft manufacturers, four levels of fault management support can be distinguished (see Table 1). These characterizations are not one-to-one relationships to what the manufacturers offer but rather are inspired by how these systems work:

1. Show All. This was inspired by the Boeing 777 method of showing all the fault messages with very little prioritization or processing of the relationships between the faults. The only inhibition is of clear direct subsystem failures messages. Severity is predetermined for each individual message, and the level is set by color. The messages are displayed in a chronological order, which may result in the primary fault appearing at the bottom of the list.

2. Sort & Show. This was inspired by the Saab 2000 method of inhibiting all the messages that do not require pilot action when a high-level warning is presented. Severity even here is predetermined by colors, and messages are displayed chronologically. System logic sorts the messages of the same color and presents the primary fault (when known) at the top of the list. If a failure results in automatic system reconfiguration, this is usually shown. This method results in shorter lists and usually a primary fault at the top.

Display Philosophy	Modeled on Aircraft Type	Display Features in Aviation Domain Language
"Show All"	Boeing 777	All failed systems displayed
		RED/AMBER priority only
		RED only if single failure critical
		Direct subsystem failures not shown
		Failures shown chronologically
"Sort & Show"	Saab 2000	Predetermined declutter when no crew action
		RED/AMBER priority
		Direct subsystem failures not shown
		Clear primary failure shown on top
		Automatic reconfigurations not shown
"Sort & Guide"	Airbus 320	Full predetermined priority
		RED/AMBER priority
		Only one failure (most urgent) presented at a time
		Guidance for immediate action follows failure message
		Subsystems presented as status only
		Automatic reconfigurations not shown
"Do & Show"	Boeing MD-11	Full predetermined priority
		Combined failure effect stated ("DUAL")
		Automatic system reconfiguration-information to crew
		Guidance when crew action required

TABLE 1 The Four Warning Systems Tested in This Study

3. *Sort & Guide*. This was inspired by the A320 method of a fully defined logic for message prioritization. In addition, only one failure is shown at a time, along with the immediate-actions required of the pilot. Subsystem information is displayed on demand on a lower level display. This results in a clear information to the pilot of the primary fault and guidance for recovery.

4. *Do & Show*. This was inspired by the MD11 method, in which the system has a high degree of autonomy and can react to failures without pilot action. The only exceptions are non-reversible actions (such as engine shutdown). For the majority of the failures the system informs the pilot of system reconfiguration and present status. In addition, the system recognizes a combination of failures and gives a common name to the higher level of fault (dual engine).

# EXPECTED RESULTS

Given that the representational nature of these systems does not differ fundamentally (showing the status of single failed components), performance benefits would have to derive predominantly from the way in which these systems contribute to failure management. Warning systems that basically pass a cascade of failures on to the human as they come in over time (such as the Show All system) have led to human performance decrements during critical incidents; for example, inabilities to identify root causes or visualize the state of the process (Billings & Dekker, 1996; Potter & Woods, 1991). Short of profoundly re-evaluating the representational nature of commercial aircraft warning systems (i.e., reconsidering what are actually the interesting changes, events, and implications and readjusting the representation's referents on the

basis of that), other available warning systems depart from the Show All system by doing more failure management themselves. Performance benefits could accrue if these properties support the dynamic fault management task.

• Modest performance benefits can be expected if the system itself makes some decisions about what warnings to represent in the first place. If presented failures carry no relevance to the situation at hand, or do not require human action, their inhibition may improve performance on concurrent tasks and assessments associated with dynamic fault management. The Sort & Show system is an example of a system that inhibits failure presentation to some extent: It prioritizes failures and shows them only selectively.

• Furthermore, a system that sorts through the failures, presents them selectively, and guides the pilot in what to do next or where to look next, in addition to sorting through the failures, would support the dynamic fault management task: Both problem structure and subsequent actions (and implicit couplings between them that the pilot may recognize) are illuminated. The Sort & Guide system is an example of this, because it prioritizes failures, shows them selectively, and guides the operator in what to do next.

• Finally, a system that corrects or mitigates failures itself and then shows only what it has done and what is left operational can be expected to carry performance benefits for the dynamic fault management task. Pilots are aided in their understanding of how their process integrity is affected by the failures that occurred and can project their consequences into the future (i.e., what implications they carry for the rest of the flight). The Do & Show system is an example of this.

# METHOD

We set up a part-task simulation experiment to assess the human performance benefits associated with four different aircraft warning systems. One hundred twenty-eight approaches on which complex, multiple failures occurred were flown by 8 professional pilots in a part-task flight simulator. The approach phase was chosen because it is known for its higher workload and multiple interleaving tasks. Each of the 16 approaches flown by every pilot contained one out of four dynamic failure scenarios in which a fault combination produced a cascade of secondary failures (see Table 2, which also shows how the various displayed failures would look to the pilot in the different warning systems).

The list of messages was displayed at once, to create a common reference point from which to measure response times (RTs) across different warning systems. Also, display formats of the different warning systems were standardized with a common font. Each of the four failure scenarios was presented to every pilot four times, using a different underlying warning system to represent them every time. Thus, a pilot would be confronted with, for example, a loss of hydraulic systems on a total of 4 approaches, but each time the amount of support the warning system offered in terms of prioritizing, filtering, or mitigating the failures would differ. The four failure scenarios, as well as the underlying warning system representing them, were randomized across the 16 approaches each pilot made, and the order was different for each of the 8 participating pilots. The altitude (and thus distance from the runway) at which faults occurred also was randomized.

	The Representatio	n of the Different Failure Sce	The Representation of the Different Failure Scenarios in the Four Warning Systems Tested in This Study	ystems Tested in This Study	
Primary Fault	Secondary Faults	"Show All"	"Sort & Show"	"Sort & Guide"	"Do & Show"
Loss of all engines	Loss of generated electrical power Degraded flight controls Loss of anti-icing Loss of cabin pressure	L HYD MEK FAULT R HYD MEK FAULT L HYD STBY FAULT R HYD STBY FAULT R HYD STBY FAULT L ELEVATOR DEGRADE R ELEVATOR DEGRADE R ELEVATOR DEGRADE R ELEVATOR DEGRADE R ELEVATOR DEGRADE R ELEVATOR DEGRADE R ALLERON DEGRADE L ALLERON DEGRADE L GEN FAULT R GEN FAULT R GEN FAULT	<b>BAT MODE ONLY L ENG FAIL R ENG FAIL</b> L GEN FAULT R GEN FAULT	L ENG FAIL R ENG FAIL SHUT RIGHT ENGINE SHUT LEFT ENGINE	DUAL ENGINE FAIL ELEVATOR STBY ON AILERON STBY ON RUDDER STBY ON HYD STBY ON HYD STBY ON GLIDE SPEED 180
Loss of hydraulic pressure to all but essential flight controls	Degraded ailerons Degraded rudder Degraded elevator Loss of normal gear operations Degraded brakes Loss of flap operation	L ELEVATOR DEGRADE R ELEVATOR DEGRADE R UDDER DEGRADE L AILERON DEGRADE R AILERON DEGRADE L HYD MEK FAULT R HYD MEK FAULT L HYD STBY FAULT R HYD STBY FAULT	L HYD STBY FAULT R HYD STBY FAULT L ELEVATOR DEGRADE R ELEVATOR DEGRADE RUDDER DEGRADE L AILERON DEGRADE R AILERON DEGRADE R AILERON DEGRADE	L HYD FAULT R HYD FAULT START L HYD PUMP START R HYD PUMP	HYD STBY ONLY ELEVATOR STBY ON AILERON STBY ON RUDDER STBY ON
Loss of all but STBY airspeed information	Loss of elevator gearing Loss of rudder gearing Loss of aileron gearing Degraded engine function Degraded navigation	ELEVATOR GEARING RUDDER LIMITER LAIRSPEED INOP RAIRSPEED INOP LENG MAINT RENG MAINT RENG MAINT LELEVATOR AUG RELEVATOR AUG RELEVATOR AUG RELEVATOR AUG RELEVATOR AUG RELEVATOR AUG RELEVATOR AUG	ELEVATOR GEARING RUDDER LIMITER L AIRSPEED INOP R AIRSPEED INOP R AIRSPEED INOP L ELEVATOR AUGMENT R ELEVATOR AUGMENT RUDDER AUGMENT FMS DEGRADE	L AIRSPEED INOP R AIRSPEED INOP ENVELOPE PROTECT INOP USE STBY AIRSPEED	<b>STBY AIRSPEED ONLY</b> ELEVATOR STBY ON AILERON STBY ON RUDDER STBY ON

TABLE 2 on of the Different Failure Scenarios in the Four Warning Systems Te (Continued)

**BATTERY MODE ONLY 60 MIN ENDURANCE** CABIN PRESS MAN LOAD SHED DONE "Do & Show" ENVELOPE PROTECT INOP BATTERY MODE ONLY REDUCE ELEC LOAD "Sort & Guide" **BATTERY MODE ONLY** CABIN PRESS AUTO FAIL "Sort & Show" **BATTERY MODE ONLY** L ELEVATOR DEGRADE **R ELEVATOR DEGRADE RUDDER LIMIT INOP** EICAS COMPARE INOP ELEVATOR GEARING L AILERON DEGRADE R AILERON DEGRADE CABIN PRESS AUTO C HYD PUMP INOP "Show All" ICE DET FAULT R GEN FAULT L GEN FAULT FAIL Secondary Faults Degraded flight controls Loss of cabin pressure Degraded navigation Loss of anti-icing Primary Fault Loss of all but generated electrical power

*Note.* Text in boldface type appeared red on the visual display; other text was amber.

TABLE 2 (Continued)

#### Participants

Eight professional pilots (all male, mean age 47.2 years, mean experience 15 years) participated in this study. Each had substantial operating experience as pilot in command on complex aircraft with flat-panel or CRT display warning systems, which were simulated in this study. All subject pilots flew their approaches within a 2-week period.

### Materials

The part-task simulator was constructed from a virtual applications prototyping system simulation tool based on a Silicon Graphics workstation, with a PC-based flight simulator that featured realistic engine and flight controls. The flight simulator was not coupled to the warning display simulator and therefore produced no feedback in terms of thrust or flight control anomalies. However, no recovery action was required of pilots—the emphasis in this study was on their understanding and identification of failures. Pilots had dual displays: one warning display typical in layout and character of those found in "glass cockpits" of airliners today and one head-up flight guidance system (HGS) display (a glass plate showing critical flight parameters) through which the runway was visible. The HGS was modeled after a system that is becoming increasingly common on transport aircraft across the world, but none of the pilots in this study actually had much prior experience with this HGS. The part-task simulator was set up in a center for virtual reality and simulation at the participating pilot's home base.

# Tasks and Instructions

Before beginning their 16 approaches, pilots received a 30-min briefing on the aircraft, its systems, the HGS, and the tasks required of them. They were allowed as many training approaches on the simulator as they felt they needed.

For the actual approaches, pilots were asked to identify the primary faults in the failure scenario they were confronted with as quickly as they could. As soon as they were confident they had identified the primary fault that was to be addressed, they were to indicate this by pressing a button. We kept track of RTs. We checked whether the pilots' assessments were correct by presenting pilots with a multiple-choice question on the warning system display. This question laid out four alternative primary faults. To minimize learning over the 16 approaches, pilots were not shown whether they had made the right or the wrong assessments about the primary fault in a failure scenario. In addition, the order of failure scenarios and warning systems was randomized across the 8 participating pilots.

To reflect the dual nature of dynamic fault management, pilots were asked not only to examine the failures presented and to try to understand them but also to maintain process integrity at the same time—in this case, keeping the aircraft on a stable approach to the runway. Near the end of an approach, this is known to be a high-gain tracking task. The simulator used in this study was chosen for its capability to monitor pilot performance on all the relevant parameters of the task, in this case air speed, sink rate, predicted touchdown point, and lateral and vertical deviations from the electronic signals guiding the aircraft toward the runway (the *instrument landing system*). This simulator dynamically measured pilot performance during the complete approach phase, narrowing the allowable window of deviations as the aircraft got closer to the runway. If the subject pilot exceeded the safe level of any of the parameters, a message ("APPROACH WARN") was displayed and, if no corrective action were initiated after 1 sec, the approach would be considered to have failed.

# 72 SINGER AND DEKKER

Performance data from failed approaches were considered in the analysis of the results. Once the entire experiment was over, subject pilots were shown their own performance results (i.e., RTs and correctness in identifying the various faults), and the purpose of the experiment was explained.

#### RESULTS

The participant pilots all judged the part-task simulation approaches to be realistic, given their purpose, and commented that the workload experienced was typical of the task and circumstances with which they usually were confronted. All participant pilots appeared motivated and took the task to a professional level, trying to give the quickest and best response. No technical anomalies occurred during any of the 128 approaches flown.

Figure 1 shows the mean RTs and error rates on the four different warning systems evaluated in this study. On Warning System 3, Sort & Guide, pilots were quickest to acknowledge that they had understood the failure scenario and recognized the primary fault, and indeed made no erroneous assessments of the failure scenario. Following closely in mean RT, Warning System 4—Do & Show—also produced a zero error rate. Warning System 1, Show All, led to the longest RTs and highest error rates. Only one failed approach occurred, and it was on Warning System 1.

To evaluate whether the different warning systems produced significantly different RTs and what effect, if any, the kind of failure scenario had on these RTs, we conducted a two-way analysis of variance (with effect on RT of warning system, failure scenario, and their interaction, as the variables). The kind of warning system had a highly significant effect on RTs, F(3, 84) = 24.56, p < .0001, whereas the kind of failure scenario had a more modest but still significant effect, F(3, 28) = 3.18, p < .04. We also found a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant interaction between the kind of failure scenario had a significant scenario had a sc

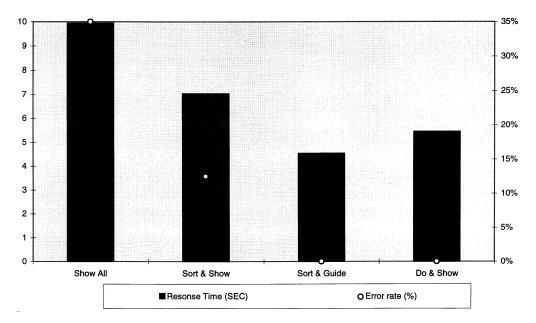


FIGURE 1 Response times and error rates on the four warning systems tested in this study. SEC = seconds.

ure scenario with which the pilot was confronted and the kind of warning system on which the failures were shown, F(9, 84) = 4.09, p < .0002, as shown in Figure 2.

A post hoc test, Tukey's honestly significant difference test, revealed how performance on Warning System 1 (Show All) was significantly worse than on all others. Performance on the best-scoring system (Warning System 3, Sort & Guide) was significantly better than performance on Warning Systems 1 and 2 (Sort & Show) but not significantly better than performance on Warning System 4 (Do & Show). This confirmed how Warning Systems 3 and 4 followed one another closely in fault identification times.

## DISCUSSION

Figure 2 shows the mean RTs across the warning systems and failure scenarios. The engine failure scenario reveals a moderate improvement in RT as the participant pilots moved toward systems with higher levels of guidance. This is to be expected, because engine failures are almost always a primary cause of failures in other aircraft systems. This also goes for air speed failures, given the intricate connection between air speed data and highly automated flight control and engine systems.

The long mean RT on the Show All system in the electrical failure case could be attributed to the long list of messages this warning system produces (all in amber), which requires longer reading time. Indeed, message list length is obviously an artifact of the warning system. But longer reading time should not produce higher error rates—if anything, it should produce lower error rates (the speed–accuracy tradeoff; see Wickens, 1992). Yet the Show All system produced higher error rates than any other system. Thus, message list length does not really explain the performance differences

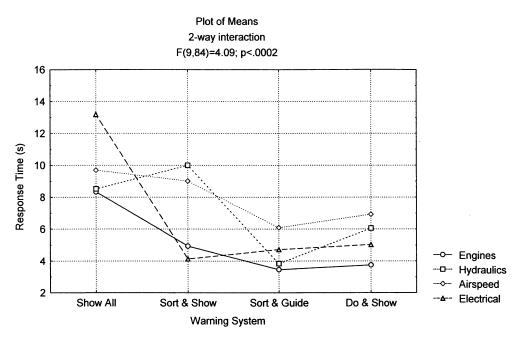


FIGURE 2 Plot of means: Two-way interaction of warning systems and failures.

observed in this study. It is significant that the only failed approach in this study occurred on the Show All system. It is possible that in this case the pilot fixed his attention on the warning display in an attempt to understand what was in this case an electrical failure, showing a long dwell time for a display that demands a lot of cognitive work to be understood (Wickens, 1992).

The large step in the hydraulic failure case could be explained partially by the color coding in red of the primary failure, which would help the identification of the primary fault. The same effect of color coding could be one cause of lower RTs in the engine failure case, at least on the three displays that use such coding, a result that confirms the importance of the role of representation in affecting human performance. More research must be done to try to isolate dominant warning systems and representational features that influence performance.

Overall, the results are consistent with expectations of how various warning systems would aid humans in their dynamic fault management. Human performance gains become visible as soon as the warning system itself manages various failures in some way before presenting them. There is an increment in these performance gains, based on the nature of the warning system and depth to which it supports the failure management task. Modest performance benefits are associated with a system that sorts the failures and shows them selectively, but some errors in identifying the primary fault still occur. Performance benefits really accrue with a system that sorts through the failures, shows them selectively, and guides the pilot in what to do next. In this study, pilots were quickest to identify the primary fault in the failure scenario with such a system and made no errors in assessing what it was. Similarly, a warning system that itself contains or counteracts many of the failures and shows mainly what is left to the pilot scores low RTs and zero error rates in identifying the primary fault.

Part-task simulation has been accepted as a more naturalistic extension to laboratory-based experimental research (Brehmer, Leplat, & Rasmussen, 1991), especially when used to create operational environments in which actual expert practitioners can carry out meaningful domain work. The tractability of such an experimental setting provides clear benefits in terms of control over variance. This internal tightness is not only created, but also counterbalanced, by the austerity of the overall setting (only one pilot in interaction with a few systems). Such a spartan approach carries consequences for the transportability of the results to richer circumstances, in which multiple crew members can interact in their responses to failures and have to juggle a larger set of simultaneous tasks as well. Also, the occurrence of a failure scenario on every approach has little connection to operational reality. On the other hand, however, such failure frequency is typical of pilot recurrency or type training on simulators.

Finally, the mismatch between performance results (best performance on the Sort & Guide system) and interview data (pilots disliking guidance about internal failures; Mårtensson & Singer, 1998) is interesting; it reveals how hard it can be for practitioners to express clearly to designers what may help or hinder their problem solving most. Such data can serve as a warning for designers and certification authorities who rely on subjective pilot opinions as only human factors input to their system development and assessment activities.

# CONCLUSION

Commercial aviation warning systems today provide message lists that represent single systems with status statements coded in a particular color. They differ in how they contribute to managing the failures. Human performance benefits become evident when warning systems support the dynamic fault management task, in which practitioners have to sort out and diagnose a cascade of failures while maintaining process integrity at the same time. Given these demands, practi-

tioners benefit from seeing interconnections and hierarchies among failures, future degradations, additional failures to be expected, and plausible system reconfigurations to maintain process integrity.

This study showed that the way in which warning systems contribute to failure management has consequences for human performance. For example, a system that guides the pilot in what to do next or that shows the pilot what is still operational carries clear performance benefits. These results, however, should not be seen as justification for simply automating more of the failure management task. Human performance difficulties associated with high automation participation in difficult or novel circumstances—such as brittle procedure following (Roth & Woods, 1989), in which operators follow heuristic cues from the automation rather than actively seeking and processing information related to the disturbance chain (Mosier, Skitka, Heers, & Burdick, 1997)—are well known.

Instead, these results indicate how progress can be made by changing the representational quality of warning systems altogether, not just by automating more of the human task portion. If guidance is beneficial, and if knowing what is still operational is useful to the pilot, then the results of this study tell designers of warning systems to shift to another view of referents. Designers would have to get away from relying on single systems and their status as referents to show on the display and move toward referents that fix on higher order variables that carry more meaning relative to the dynamic fault management task. Referents could integrate current status with future predictions, for example, or could cut across single parameters and individual systems to reveal structure behind individual failures and show consequences in terms that are operationally immediately meaningful (e.g., loss of pressure, loss of thrust). To effectively support dynamic fault management, referents would have to convey the following (see also Johns, 1990):

- The threat a disturbance chain represents to overall system safety.
- Interconnections and hierarchies among individual failures so that a problem solver can recognize the structure of the underlying problem.
- Changes and events that are happening now or in the near future so that a problem solver can track developments or trends.
- Ramifications of the current problem in terms of what is or will be left operational, so that a problem solver can judge the consequences of the failures for overall system integrity.

Some designers will argue that such recognition and judgments are possible only on the basis of pilot expertise or, in the words of Don Norman (1993), that it is not knowledge which can be put in the world; it has to be in the head. The limitations of this approach (that training should absorb design deficiencies) are severe, deep, and much commented on (e.g., FAA, 1996). In this study the immediate performance benefits associated with warning systems that (a) provide guidance on what to do next and (b) show the pilot what is still operational confirm that those kinds of referents would be useful given dynamic fault management demands.

# ACKNOWLEDGMENTS

This work was supported by the Swedish Program in Aeronautical Research, Saab AB, and by a grant from the Flight Safety Department at the Swedish Civil Aviation Authority.

We are grateful to Håkan Alm for useful guidance and comments in preparing the final analysis and to the Center for Virtual Reality and Simulation in Linköping, Christiano Masi in particular.

#### 76 SINGER AND DEKKER

#### REFERENCES

- Billings, C. E. (1996). Aviation automation: The search for a human centered approach. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Billings, C. E., & Dekker, S. W. A. (1996). Advanced and novel automation concepts for the future system. In C. E. Billings, *Aviation automation: The search for a human centered approach* (pp. 221–231). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Brehmer, B., Leplat, J., & Rasmussen, J. (1991). Use of simulation in the study of complex decision making. In J. Rasmussen, B. Brehmer, & J. Leplat (Eds.), *Distributed decision making: Cognitive models for cooperative work* (pp. 373–386). New York: Wiley.
- Courteney, H. (1999). Human factors of automation: The regulator's challenge. In S. W. A. Dekker & E. Hollnagel (Eds.), *Coping with computers in the cockpit* (pp. 109–130). Aldershot, England: Ashgate.
- Federal Aviation Administration. (1996). Human factors Study Team report on the interface between flightcrews and modern flight deck systems. Washington, DC: Author.
- Hicks, M., & De Brito, G. (1998). Civil aircraft warning systems: Who's calling the shots? *Proceedings of HCI–Aero* '98, the International Conference on Human–Computer Interaction in Aeronautics. Montreal, Canada.
- Johns, G. L. (1990). Graphical interfaces to intelligent fault management systems: Issues and guidelines (Rep. No. MTR-90W00103). Houston, TX: National Aeronautics and Space Administration.
- Klein, G. (1998). Sources of power: How people make decisions. Cambridge, MA: MIT Press.
- Mårtensson, L., & Singer, G. (1998). Warning systems in commercial aircraft: An analysis of existing systems (Rep. No. TRITA-IEO-1998:01). Stockholm: Royal Institute of Technology.
- Mosier, K. L., Skitka, L. J., Heers, S., & Burdick, M. (1997). Automation bias: Decision making and performance in high-tech cockpits. *International Journal of Aviation Psychology*, 8, 47–64.
- Norman, D. A. (1993). Things that make us smart. Reading, MA: Addison-Wesley.
- Potter, S. S., & Woods, D. D. (1991). Event driven timeline displays: Beyond message lists in human–intelligent system interaction. *IEEE*, 8, 1283–1288.
- Roth, E. M., & Woods, D. D. (1989). Cognitive task analysis: An approach to knowledge acquisition for intelligent system design. In G. Guida & C. Tasso (Eds.), *Topics in expert system design* (pp. 153–178). New York: North-Holland. Simon, H. (1969). *Sciences of the artificial*. Cambridge, MA: MIT Press.
- Wickens, C. D. (1992). Engineering psychology and human performance. New York: HarperCollins.
- Woods, D. D. (1994). Cognitive demands and activities in dynamic fault management: Abduction and disturbance management. In N. Stanton (Ed.), *Human factors of alarm design* (pp. 88–107). London: Taylor & Francis.
- Woods, D. D. (1995). Towards a theoretical base for representation design in the computer medium: Ecological perception and aiding human cognition. In J. Flack, P. Hancock, J. Caird, & K. Vincente (Eds.), *Global perspectives on the ecology of human–machine systems* (pp. 106–128). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Copyright of Transportation Human Factors is the property of Lawrence Erlbaum Associates and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.