Reshaping crisis management: the challenge for organizational design

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Abstract:

A new approach to crisis management is emerging which progresses beyond a purely reactive response and creates fresh opportunities for improved organizational development. This paper outlines the traditional event approach to crisis management, which focuses on preparing for and responding to a major adverse occurrence, and discusses the new process approach, which reshapes crisis management within a broader continuum of management activity. Crisis prevention instead of just crisis response necessitates moving responsibility from the operational to the executive level, and the paper builds on a nonlinear model to explore how crisis management activities can be clustered together and integrated to optimize organizational effectiveness.

Introduction

Virtually nothing can damage organizational reputation and financial performance more rapidly and more deeply than the impact of a major crisis. Yet many organizations continue to delegate responsibility for crisis management to operational middle managers, while reputation management increasingly secures a place at the executive table.

However a significant trend in crisis management is now emerging which has the potential to reshape the discipline with substantial implications for the development of organizational structure and design. This trend is the advance of proactive crisis prevention as opposed to reactive crisis response, which brings with it more comprehensive parameters of what should be recognized as integral elements of crisis management within a broader continuum of management activities.

In order to properly understand the emerging shape of crisis management it is essential to appreciate the longer term evolution of the discipline. It is also important to recognize that in the present discussion the term crisis is used to refer primarily to organizational crises – where particular organizations or groups of organizations are specifically impacted. This discussion is not intended to focus on societal crises – including natural disasters such as earthquakes, hurricanes, forest fires or even climate change – where individual organizations may be affected but only as part of broader community or national impact.

The British scholar Denis Smith observed in 2005: "The definition of crisis has generated considerable debate within the academic literature and there is no real collective acceptance about the precise meaning of the term" (p. 319).

Yet there is a good deal of academic and practitioner support for the broad concept of a crisis fundamentally as a low probability and highly damaging occurrence. A frequently cited descriptive definition is that developed by Pearson and Clair (1998): "An organizational crisis is a high impact event that threatens the viability of the organization and is characterized by ambiguity of cause, effect and means of resolution, as well as by a belief that decisions must be made swiftly" (p. 60).

The event approach

The traditional approach, which regards a crisis as an adverse event, has been present since organizational crisis management first appeared as a fully recognized independent discipline in the United States after the Tylenol poisoning on 1982 (Heath & Palenchar, 2009) and in Europe following the Chernobyl crisis of 1986 (Falkheimer & Heide, 2006).

This so-called event approach led to a very logical conceptualization of crisis management as a largely tactical activity focused on incident response – what to do when a crisis occurs and how to prepare for it in case it happens. Such functional activities are critically important for successful organizational crisis response and recovery and the event approach retains widespread support, for example: "A crisis is a sudden and unexpected event that threatens to disrupt an organization's operations and poses both a financial and reputations threat" (Coombs, 2007, p. 164) or "A crisis is an unplanned (but not necessarily unexpected) event that calls for real time high level strategic decisions in circumstances where making the wrong decisions, or not responding quickly or proactively enough, could seriously harm the organization" (Davies, 2005, p. 69).

From the perspective of organizational development, this traditional event approach typically positions crisis management structurally alongside operational or technical functions such as security or emergency response, often with public affairs tactically in support, mainly for media or community relations.

The process approach

More recent developments have seen a distinct tendency for crisis management to evolve beyond this operationalized response, and it is this reshaping of crisis management which has led to the need for new organizational design.

At the heart of this evolution is a growing awareness that proactive managers can and should take steps to avoid a crisis happening in the first place. This has led to increasing acceptance of crisis management as part of a process continuum, which builds on the recognition (a) that most crises are not sudden events but follow a period of precognition and red flags and (b) that leaders and managers have a wide range of proactive processes

and activities which can be implemented to identify, pre-empt and prevent potential crises, or to mitigate those which do occur.

The crisis experts Pauchant and Mitroff captured this new approach when they coined the neat distinction crash management versus crisis management. “Crisis management is not the same as crash management – what to do when everything falls apart. Obviously this is important, but it is only one part of total crisis management effort. Here we focus not only on crash management – what to do in the heat of a crisis – but also on why crises happen in the first place and what can be done to prevent them” (Pauchant & Mitroff, 1992, p. 11).

One of the early American scholars to champion this process approach was Shrivastava: “Crises are not events, but processes extended in time and place” (1995, p. 2), and the concept was subsequently taken up very strongly by European academics: “Crises are not discrete events, but rather high intensity nodes in ongoing streams of social interaction” (‘t Hart, Heyse & Boin, 2000, p. 185).

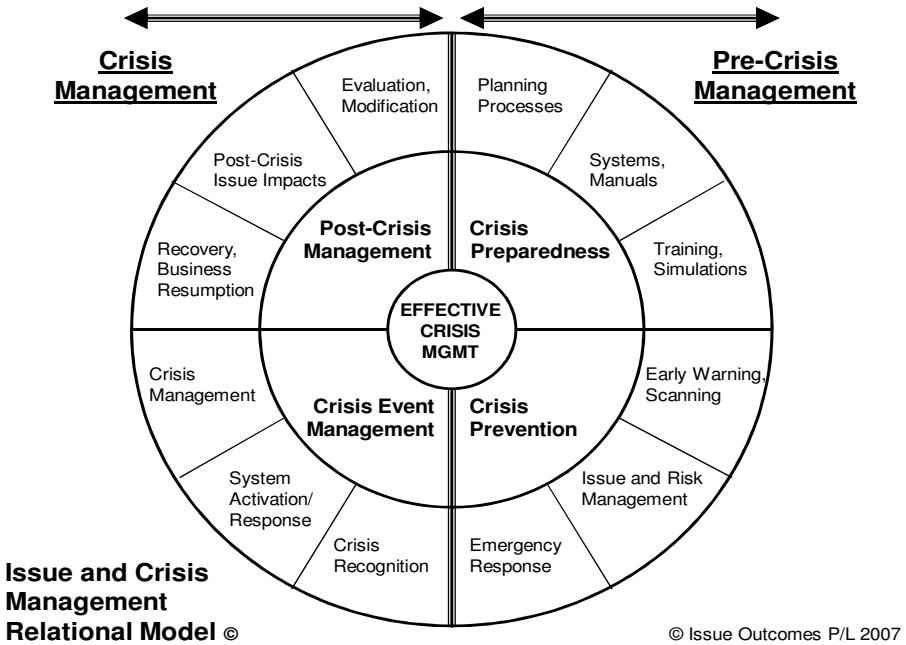
There is an obvious complementarity between the event approach and the process approach to crisis management and the evolution of the two approaches and their relative merits has been analyzed in detail (see for example Forgues & Roux-Dufort, 1998; Jaques 2009a; Roux-Dufort, 2007). But the challenge in the present context is how to represent the new process approach in a way which translates into structural design, utilizing the continuum of established management terminology and activity.

Given the diversity of organizational needs there is no best practice model and many organizations reflect a combination of both the event and the process approach to crisis management. Indeed, Roux-Dufort (2007) has argued that, despite increasing acceptance of the process approach, the crisis management literature still mostly develops the event approach, while the process approach has been less used and developed, both theoretically and in practice.

Broadly however the essential concept in terms of organizational development is the growing recognition that crisis prevention is a critically important element of total crisis management.

Developing an integrated construct

One response to representing the process continuum beyond the event approach is the development of a more fully integrated, non-linear model which establishes crisis management as a cyclical construct (Jaques, 2007).



Unlike more traditional models, which build on a conventional linear sequence such as problem-issue-crisis-resolution, this nonlinear construct emphasizes that the elements should be seen not as sequential steps but as clusters of related and integrated activities which may overlap or occur simultaneously.

The cyclical nature of the model also emphasizes that issues and crises are rarely conventionally 'resolved' – certainly not in the short term – and that management systems need to be in place to manage longer term impacts and feed back learnings to help the organization be better prepared for future problems.

An important aspect of this model is the division of the pre-crisis phase into two distinct parts – crisis preparedness and crisis prevention. Crisis preparedness includes many of the basic activities, such as planning processes, systems and manuals, documentation and traditional exercises and simulations. These are important in making the organization better prepared to respond operationally to future crises, but do very little to prevent crises, which will still result in damage to the organization and its reputation.

Alongside this is a separate cluster of activities characterized as crisis prevention, and these include early warning systems, risk and issue management, social forecasting, environmental scanning and emergency response.

In effect these two distinct segments separate the mechanistic from the strategic, and that has direct implications for how organizations are structured and managed. But before considering the organizational implications it is necessary to focus on the fourth segment of the model, namely post-crisis management (for fuller discussion of the post-crisis phase see Jaques, 2009b).

Learning in the post-crisis phase

When the 'active' management phase of a crisis has passed – for example the fire is extinguished, the faulty product has been recalled, the corporate wrongdoer is removed – it is a very natural management tendency to focus on moving on from the crisis and returning to 'business as usual' as quickly as possible. In fact there is an extensive literature regarding the barriers to management learning and organizational improvement in the aftermath of a crisis (for example Elliott, Smith & McGuinness, 2000; Gibson 2000; Jaques, 2008; Kovoor-Misra, Zammuto & Mitroff, 2000; Mitroff & Pauchant, 1990; Roux-Dufort, 2000; Stern, 1997).

Despite the understandable resistance by any organization to frank assessment of its own shortcomings, the post-crisis phase of this model reinforces the cyclical nature of the process, feeding directly back into the planning/preparedness element.

The period after a crisis has been described as representing "an opportunity to change those aspects of the organization which helped create the potential for a crisis in the first place" (Elliott et al, p. 21) or "a privileged moment during which to understand things differently" (Roux-Dufort, 2000, p. 26). However such change is unlikely without the organizational intent and structure to help make it possible.

Effectively the two important organizational challenges arising from this evolution are (a) that preventive activities are not traditionally regarded as part of crisis management and (b) they should not rest with the operational middle managers typically tasked with responsibility for crisis management.

A way forward for optimal effectiveness

Although many CEOs and senior executives would prefer not to think about crises, they should be concerned to reduce risk, prevent crisis and protect the organization's reputation and bottom line. The most effective way forward is to institutionalize a genuine crisis prevention mindset instead of just focusing on crisis response. But to establish such a mindset and optimize the emerging new shape of crisis management, organizational changes need to be made in four broad areas.

(1) Proactively addressing underlying systemic causes of potential crises

Systemic failures are a recognized cause of major crises. High profile examples include the Mitsubishi Motor quality scandal of 2004, where evidence of recall faults was deliberately suppressed (Hagiwara, 2007), and the Challenger disaster of 1986, when it was later shown that NASA management systems worked to block dissenting views (Esser & Lindoerfer, 1989; Starbuck & Milliken, 2007).

To help avoid such disasters organizational leaders need to integrate issue and crisis management into strategic planning; to ensure a no-fault environment to encourage reporting of near misses; and be prepared to encourage and willingly accept bad news and

dissenting opinions. Going further, Brown (2002) suggests that the greater systemic challenges for organizational structures are not simply a lack of good information, but lack of imagination; faulty or inadequate analysis; not seeing the big picture; and failure to link information to action. Such changes can happen only with full senior management commitment and support.

(2) Establishing effective mechanisms to recognize and respond to red flags

A fundamental challenge for management is not just recognizing early warnings but also having systems in place to convert those warnings into pre-emptive action. Extensive case literature demonstrates that most if not all crises are preceded by warning signals, often ignored. For example James and Wooten (2005) concluded: "smoldering crises nearly always leave a trail of red flags and warning signals that something is wrong. These signals often go unheeded by management" (p.143).

In March 2005 an explosion and fire at the BP refinery in Texas City near Houston killed 15 and injured 170 – America's worst industrial accident in a decade. The official inquiry found six underlying causes, all of which had been known to management, and a subsequent investigation of all five BP America refineries produced a devastating indictment of warnings and near misses ignored, excessive cost cutting, poor safety culture and deficient leadership right to the top of the company. After enduring more than $70 million in earlier fines and penalties, in October 2009 BP was fined a record $87 million for industrial negligence, including $31 million in "willful violations" of process safety management (Greenhouse, 2009).

Even when sound systems are theoretically in place, crisis can strike. In early 2008 Société Générale reported about $7 billion (4.9 billion euros) lost on unauthorized transactions by a single rogue trader. An independent panel found that the French bank had failed to act on 75 red flags or early warnings over 18 months (Clark, 2008).

And more recently, in the wake of the $65 billion Madoff investment scandal, SEC Inspector General David Kotz reported that the agency missed "numerous red flags" from 1992 until the fraudster was arrested in December 2008. He said five separate failed investigations into the affair had been bungled and called for major organizational change (Stout, 2009).

(3) Properly identifying stakeholders and their perspectives

The third area where change is needed is the ability to identify all the potential stakeholders, not just those the organization chooses to deal with. A textbook failure in this regard is the 1993 proposal by Disney to build an American history theme park near the civil war battlefield at Bull Run in Northern Virginia, where the proponents identified likely key concerns as traffic, noise, zoning and property values. Presenting the project as a virtual *fait accompli,* the company "ignored many influential community opinion leaders as it focused on courting local politicians and business leaders" (Wiebner, 1995, p. 44). In a classic misunderstanding of stakeholders and their perspectives, Disney misjudged the local community and misread their concerns. Less than a year later, and after a bruising and costly public relations disaster, the plan was abandoned.

Another classic example of excessive internal focus is the famous Intel Pentium crisis, when a faulty computer chip was initially downplayed because the company misread the importance of the problem and ignored its customers. The resulting recall crisis eventually cost Intel a $475 million charge against earnings and serious damage to its reputation. CEO Andy Grove later conceded the company had failed to adapt to the new environment. "We got caught between our mindset, which is a fact-based, analysis-based engineer's mindset, and customers' mindset, which is not so much emotional but accustomed to making their own choice" (Carlton & Yoder, 1994).

The important lesson here is not just listening to a wide range of stakeholders, but establishing processes to include those who don't agree with you.

(4) Implementing systematic organization learning and unlearning

As previously described, there is an established literature regarding the barriers to management learning and organizational improvement in the aftermath of a crisis. Yet there are a number of areas where organizational design can be improved to increase the chances of organizational learning.

Systems should be established to allow organizations to undertake formal reviews in order to learn from their own issues and crises, as well as the issues and crises of others. But when reviewing crises in other organizations little is achieved if managers take the *schadenfreude* approach and conclude, for example: "This won't happen to us, and even if it did we are much better prepared," or "We would be able to handle it well and avoid all those obvious mistakes" (Jaques, 2008, p. 198).

Effective organizational learning will not be achieved unless the crisis review is objective and formal, and accepted as a genuine learning opportunity, assuming a stance of open and willing curiosity. For example "Maybe this could happen to us," and "What can we learn to avoid the same mistakes?"

As Tyler commented on the notorious Exxon Valdez oil spill: "Company executives who insist that the Exxon spill was an unavoidable accident surely are less likely to work to prevent such accidents in the future. If corporate executives insist that the accident would not have occurred if Exxon rules had been followed, they have less reason to examine corporate policies and procedures and more reason to perceive themselves, unreasonably, as the victims of the situation" (Tyler, 1997, p. 65).

The final steps for organizational learning in order to help reduce the chances of a crisis occurring are to benchmark crisis management systems against peer organizations and peer industries, and to implement best practice processes for identifying and managing issues before they become crises. Only in this way organizations can objectively assess their own positions and also identify key areas for improvement. The most effective crisis management is undoubtedly to prevent a crisis happening in the first place and the reshaping of crisis management makes that increasingly possible.

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