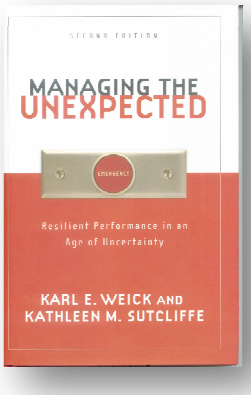
Managing the Unexpected Resilient Performance in the Age of Uncertainty, by Karl E Weick and Kathleen M Sutcliffe

A book review by Ian Jay

An engineer reports to the project director that some pre-launch tests he conducted may have caused a short circuit resulting in test failure. The director sends the engineer a bottle of champagne. On an aircraft carrier deck a technician loses a tool, reports the fact and is given a citation that same day.

In many organizations problems only come to the attention of management when the effects have a noticeable negative impact on operations. In the examples above, small but significant problems were immediately brought to the attention of management and appropriate action was taken to address the situation before control was lost.



The underlying reason many organizations do not respond quickly to an emerging crisis lies in planning. Plans have three negative effects on perceptions. First, the plan becomes an expectation of the future and individual incidents are 'fitted' to these expectations. The second problem is that plans define what can be done with contingencies, and these are typically shaped by pre-conceived ideas of what can go wrong, but they do not accommodate what is actually happening due to a lack of flexibility in the organization. The third weakness is the presumption of consistent performance from the organization. In reality human error is inevitable, no matter what quality system is in place. The organization therefore needs to deal with problems once they have arisen; this is not easy if there is a mindset that presumes errors do not arise.

To address the weaknesses described requires a culture the authors refer to as 'High Reliability Organization'. These organizations are characterized by an informed culture, in other words managers are informed of events as they arise without filtering out unwelcome news. Such a culture has four aspects; people who report mistakes and near misses are protected, problems are seen as system failures not reasons for blame, organization systems are flexible, and information from knowledgeable people is shared.

The benefits of adopting the practices explained in this book are increased ability to deal with unexpected events and incidents as they arise. This capability enables organizations to deal with new issues before they become out of control problems. This capability also results in more resilient operations that can adjust rapidly to change in its environment.

The book is based on research that identified the practices of high reliability organizations. It sets these practices out as audit checklists that are intended to be used as benchmarking tools by the reader. The first part of the book provides insight into the workings of high reliability organizations, with illustrated cases from fire fighting, nuclear power station management, and aircraft carrier flight deck operations. These are contrasted with more conventional bureaucratic systems. Examples of organization failure in NASA and the UK National Health Service are used to illustrate the benefits of moving to a high reliability culture.

The later chapters of the book provide the audit tools and implementation guidelines for managers who wish to adopt the high reliability approach. The key lies in the creation of four new sub-cultures in the organization; these are labelled reporting, just, flexible, and learning. The reporting culture is about protection of the people who report, this creates a climate that allows rare incidents and near misses to be brought to management attention so that proactive measures can be taken to prevent accidents. The just culture requires an open environment where organization members are not punished for blameless acts. The flexible culture is one where deference is paid to those with the appropriate knowledge to deal with situations as they arise, in contrast to the norm of deferring to more senior positions, this is particularly important in times of crisis. Finally the learning culture is one that involves ongoing debate about constantly arising discrepancies between expectations and events.

The final chapter suggest change through incremental steps, for example by introducing regular staff reviews or cases of failure within the organization. The chapter concludes with tips on how to manage 'mindfully' and includes examples of review questions for lessons learned exercises with staff.

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