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Disrupting Power Relations in the Risk Cycle

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Figure 1:
The Organizational Risk Cycle

The Risks of Risk Management

Ours is a society that is increasingly preoccupied with identifying and managing risks. Does increasing our attention to risk mean the world is more risky than in the past? Perhaps not, but it does mean we live in a world in which organizations are pouring resources into attempting to measure, order and control risk in various ways. However, they may be creating blind spots in doing so. Relying on neat calculations, taken-for-granted knowledge and routinized techniques and practices is unlikely to prove helpful when risks arise unexpectedly and in forms not amenable to mathematical measurement.

In dealing with a wide range of hazards – from mortgage defaults to stock market volatility, and from earthquakes to industrial accidents – the application of risk concepts and techniques has become routine. But this routine approach is, in itself, risky: by having the same conversation about risk over and over again, the way in which risk is organized becomes standard and acceptable, thereby institutionalizing practices and repeatedly reproducing the same behavior. This conversation, also known as the *discourse* of risk (see capsule #4), is made up of the interrelated concepts, documents and practices associated with risk that have developed over time. It emphasizes a *realist* approach to risk (see capsule #2) – predicting and measuring risk so as to remove uncertainty about the future.

This realist approach can lull organizations into a false sense of security – leading them to believe that they face normal, knowable and manageable risks which, if the right techniques are deployed and the right experts are consulted, can be identified and managed effectively. Organizations may fail to appreciate the complexity and unpredictability of certain hazards. They may overlook the limits of expert knowledge. They may discount local knowledge and experiences that may be indispensable when dealing with uncertain and complex risks, making it difficult for employees to improvise even when we need them to.

In capsule #2, we explained how the realist approach to risk tends to crowd out alternative approaches throughout the risk cycle. In this capsule, we explain why this is the case, showing how power relations permeate the risk cycle. We then suggest how, rather than reinforcing existing approaches to risk and repeating past failings, managers can find ways to disrupt these power relations to introduce alternative ways of addressing risk. The first step lies in understanding the cycle (also see capsule #1). The second step is disrupting the power relations that permeate it.

An Ongoing Cycle of Organizing Risk

Organizations seeking to prevent, contain and manage specific risks employ particular organizing devices, techniques and processes. We have identified three modes – prospective, real-time, and retrospective – in which the organizing of risk occurs, as individuals prepare for risk, act on it and investigate instances where risk incidents arose.

In the prospective mode, the goal is to **prepare**: to predict risks in order to prevent them from arising. In this mode, risk is typically defined by experts based on established, taken-for granted knowledge, focusing on *what may happen*. When this mode fails, risk materializes. Individuals – often those closest to it – then have to **act** in the real-time mode to control and contain the risk, by using plans, scripts and protocols to address *what is happening*. After an incident occurs, the retrospective mode of reviewing and revising is brought into play, usually by expert adjudicators who **investigate**. This typically takes the form of constructing a coherent narrative that lays blame and makes recommendations in order to address *what did happen, what should have happened,* and *what should happen* next time.

The three modes for organizing risk combine to form an ongoing risk cycle where one mode morphs into the next as risks unfold:

What may happen becomes *what is happening:* when the risk becomes more imminent and begins to materialize, and plans and protocols prepared in advance are supplemented with actions to contain the risk as it materializes (e.g. the fear that hostages might be taken becomes the reality of a siege involving hostages).

What is happening becomes *what did happen* and *what should have happened*: when a materialized risk, as well as its causes and its effects, are made the subject of an inquiry or review (e.g. after the siege situation has been resolved in some way, an inquiry examines the effectiveness and justifiability of the response of law enforcement agencies).

What should have happened becomes *what should happen:* when recommendations and lessons from the inquiry or review are factored into subsequent prospective and real-time organizing of risk (e.g. security is tightened, staff training is changed, communication channels are strengthened).

The 'Normal' Way of Organizing Risk

When organizing risk in any one of these three modes, the realist approach provides the 'normal' way of talking about and dealing with risk.

In the **prospective mode**, risk is made to seem 'normal' by predicting and preventing negative events that may happen in the future. Risk is typically assessed and managed far away in time and space from possible hazards. Scientific, technical and economic knowledge, including calculation and measurement, dominate this mode. Unfamiliar, complex or ambiguous risks that cannot be easily calculated or measured may be oversimplified or even ignored.

Supposedly 'objective' knowledge is given high status, compared to subjective knowledge. So the voices of individuals with experience are lost amidst the clamour of experts.

The difficulty facing leaders and managers trying to challenge the normal way of doing things in this mode is the taken-for-granted nature of scientific methods, which makes it difficult to imagine other ways of assessing and managing risk. To find alternatives, organizations must start raising questions about traditional approaches to risk, rather than accepting existing models, and valuing flexible roles over a fixed hierarchy of roles.

When emergency strikes, organizing risk moves into **real-time mode**, which occurs in immediate proximity to the hazard. Risk is normalized by controlling and containing what is happening in the 'right now' through plans and protocols predetermined by experts working remotely. These plans and protocols are based on past experiences, working on the assumption that understanding the past will help in managing the specific present. Yet plans and protocols might have been written to satisfy the needs of regulators or insurers, more than the needs of users. Also plans are not capabilities – they have to be enacted by people in the front line, dealing with a real-time situation that may change rapidly. In the moment, the individuals who are assessing, managing and bearing the risk may be one and the same. They may need to reject pre-determined plans and protocols. Even the best-laid plans require contextualizing, customizing and adapting in real-time as the risk materializes and deviates in some way from what was anticipated.

The main difficulty in challenging what is normal in the real-time mode is that the people involved may be constrained by a requirement to obey hierarchical directives, and to act in line with expert knowledge, rather than relying on their gut-feelings and first-hand knowledge, which tends to be undervalued. They may also fear being held responsible after the fact if they do not keep to the script. Unless the status of local, first-hand knowledge is validated and unless those in the line of fire are given discretion to act as risk arbiters, their ability to adapt and improvise will be limited.

After a hazard has occurred, organizing risk moves into the **retrospective mode**. As in the prospective mode, experts mediate at a distance from the actual incident, constructing coherent narratives from partial evidence, explaining causes, placing blame, and recommending improvements. Subjective, partial eyewitness accounts are often ignored as risk adjudicators draw on taken-for-granted assumptions, techniques and processes that, at the end of the day, fail to identify fundamental causes of risk adequately.

Challenging what is 'normal practice' is difficult in this mode because subjective knowledge of first-hand experience is undervalued compared to expert knowledge, and the separate, partial experiences of those who dealt with the risk at the time are welded together into holistic narratives and '360-degree' views of events that never existed at the time. In addition, the emphasis on finding someone to blame closes off opportunities to learn from mistakes.

Power Relations and the Three Modes

If leaders and managers are serious about challenging and improving upon the 'normal' way of dealing with risk, they must understand the complex role of power relations.

Power is understood here not as a hierarchical relationships between individuals, but as an interconnected web or network of relations enabling and constraining all those involved. One implication of this network is that outcomes, whether praiseworthy or blameworthy, cannot always be clearly attributed to particular individuals because power relations are diffused and distributed across organizational and institutional structures. These power relations derive from the discourse of risk. They operate by producing 'truths' that become the basis for action by holding in place the same devices, techniques and processes associated with the three modes for organizing risk. The role these 'truths' play goes some way toward explaining why it is difficult to imagine or act on alternatives.

Power relations shape the three modes in different ways. In the **prospective mode**, power relations intensify traditional, institutionalized techniques and processes for dealing with risk, making it difficult to acknowledge or introduce novel ways of dealing with uncertain, unfamiliar risks. In the **real-time mode**, power relations discipline individuals in proximity to the risk, and reduce the likelihood that they will deviate from prescribed protocols, even when they are obviously inadequate. Front line workers are given a script to follow beforehand; they are monitored through rank and hierarchy at the time; and any improvisation may be criticized in the event of a retrospective review later. In the **retrospective mode**, power relations result in front line employees being blamed for not having predicted or managed the risk effectively, while often exempting more senior employees from responsibility.

Disrupting Power Relations in the Cycle of Risk

The three different modes for organizing risk presented here form an ongoing risk cycle that, as a risk obsessed society, we collectively experience. The risk cycle is perpetuated by power relations deriving from the dominant discourse of risk which orders and controls risk through measurement and calculation, procedures and scripts, as well as narratives of 'operator error' and blame, to make risks seem knowable and manageable. This action creates a self-perpetuating risk cycle based on taken-for-granted knowledge and benefitting particular individuals and institutions.

Individuals organizing risk in any one of the three modes have difficulty challenging the devices, techniques that have been normalized by these power relations. Unlike hierarchical power, where individuals shape the behaviour of others by creating and exploiting dependencies, these power relations shape behaviour through taken-for-granted understandings that individuals have internalized and then draw upon to structure their interactions, giving rise to outcomes that far outstrip the influence of individuals.

Learning points

Here are six suggestions for how organizations can go about disrupting the power relations that underpin the 'normal' way of organizing risk in order to develop more flexible, calibrated strategies for dealing with risk:

1. Do not assume that experts' existing risk knowledge and models are adequate to all situations. Are you ignoring more unconventional or unorthodox sources of knowledge that would help you organize risk effectively? If so, how can you locate that knowledge and what do you need to do in order to incorporate it into your decision-making and ensure that everyone takes it seriously?

2. Expand the body of risk knowledge on which your organization draws by incorporating the perspectives of those who are at risk. Find ways of including the experience and tacit knowledge of workers on the 'front line'.

3. Avoid complacency and overconfidence in the body of risk knowledge on which your organization draws by encouraging critique and alternative perspectives. How can you create a safe culture where there are no risks to individuals in being honest and critical?

4. Appreciate and engage with the complexity of contradictory accounts of risk incidents. Resist the temptation to draw lessons by resolving these accounts and creating a single, coherent narrative that over-simplifies the situation. Instead, recognize that when a risk incident occurs, individuals 'on the ground' can only ever have partial knowledge of what is going on. Recognize also that those overseeing events – the risk arbiters – may see the 'big picture' but only from a distance. How can those two incomplete views be brought together to help individuals deal with materializing risks more effectively or change how the organization prepares for risk?

5. Consider reassigning risk identities to expand your organization's ability to deal with risk. Give your expert risk assessors, who normally develop strategies for avoiding risk, experience of being on the front line when a risk materialized. Authorize your front-line employees to act without waiting for permission from risk arbiters. Put the main risk bearers in the organization in charge of adjudicating risk incidents rather than outside experts, or make them responsible for working out how the organization can best prepare for risk, instead of your normal risk assessors.

6. Recognize that making transformational change in how your organization deals with risk depends upon allowing your employees the scope to challenge the typical hierarchy of risk identities, which privileges risk assessors, risk managers, risk arbiters and risk adjudicators over risk bearers. What organizational changes are necessary for this to happen? What adjustment problems are likely and how can you manage them?

Acknowledgements

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