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Learning from Past Crises – Do Iconic Cases Help or Hinder?

Tony Jaques

Studying past crises is accepted as important for managerial and organizational learning, yet experience suggests there has been little improvement over time in overall crisis response. This paper considers the reasons for this failure and revisits some iconic organizational crises – including Tylenol and Exxon Valdez – to question if they merit the attention they receive. The paper also explores the way in which misleading or inappropriate lessons can easily be drawn from such cases and asks how relevant they are today. Moreover, does a persistent focus on a very limited number of historic cases help or hinder improving management best practice and should we instead identify and analyze 'new icons' from more recent experience.

Introduction

Management scholars often delve into the distant past for dramatic events which can be re-interpreted to provide lessons for modern organizations and often to reinforce the notion of failure to learn from history.

Typical of this approach are the loss of the Swedish warship *Vasa* in 1628, presented as a failure of the new product development process (Kessler, Bierly & Gopalakrsihnan, 2001); Napoleon's disastrous 1812 withdrawal from Moscow, re-packaged to illustrate the cost of management hubris (Kroll, Toombs & Wright, 2000); and the much-interpreted *Titanic* disaster in 1912, analysed in terms of public relations (Ziaukas, 1999) and crisis communication (Smith, 1995).

In the same way that such retrospective re-analysis regularly draws on historic disasters and failures, organizational crisis management study also tends to focus not on examples of good practice but instead on examples of faulty decisions and failure to learn from mistakes of the past.

Napoleon Bonaparte himself is reported to have said "What is history but a fable agreed upon?" and this paper explores whether some of the iconic fables of crisis management – what Mitroff and Anagnos (2000) call the 'ancient history' of the discipline – help or hinder improving best practice for contemporary managers.

Tony Jaques, Ph.D., is a Sessional Lecturer in the School of Applied Communication at RMIT University in Melbourne, Australia, Tony.jaques@rmit.edu.au.

Organizational Learning

The crisis management scholar Roux-Dufort has described crises as "a privileged moment during which to understand things differently" (2000, p. 26) and there is a well-established literature on organizational learning in the wake of crises and disasters (for example Kovoor-Misra & Nathan, 2000; Mitroff, 2002; Nystrom & Starbuck, 1984; Shrivastava, 1998; Stern, 1997; Turner & Toft, 1988;). But, sadly, there is also extensive scholarship on the proven barriers to effective post-crisis learning (for example Elliott, Smith & McGuinness, 2000; Lagadec, 1997; Mitroff & Pauchant, 1990; Roux-Dufort, 2000; Smith & Elliott, 2007).

The scholarship generally divides into two overlapping areas – how organizations learn (or don't learn) from their own crisis, and how organizations can learn from crises which have affected others. But beyond the well-researched field of post-crisis organizational learning, the question remains how to optimise the learning from specific case studies, in particular from high profile iconic cases. Such benchmark crises rarely strike the same organization more than once, so there are relatively few published examples in terms of how individual organizations have been able to demonstrate learning from one crisis to deal with the next. Well documented comparative studies where a major crisis had struck the same organization twice would include NASA's response to the 1986 *Challenger* and 2003 *Columbia* disasters (Martin & Boynston 2005); Firestone's handling of the 1978 and 2000 tyre recalls (Gibson 2000); and salmonella outbreaks in 1955 and 2000 for Japan's Snow Brand (Wrigley, Ota & Kikuchi, 2006).

In addition there are a few cases where an organization involved in an iconic crisis later faced a less well known similar incident. This paper will consider four such cases, involving successive incidents at Intel, Exxon, Gerber and Johnson and Johnson. In the first case, the iconic 1994 Intel Pentium chip recall is usually taken to exemplify what happens when a company with an 'engineering mindset' remains in denial and puts it own perception of a problem ahead of the perception of its customers (see for example Hearit, 1999). The eventual recall cost Intel $475 million and a damaging blow to its reputation.

Less widely reported is how Intel responded two years later when it found the Pentium chip was not as fast as claimed. On that occasion the company immediately apologized and Intel Communications Director Howard High said: "We've changed the position of the company on how we handle this sort of thing. Now we put the information out there and let people determine whether it's important to them." Mr High said sales were not substantially affected (Mitroff, Harrington & Gai, 1996).

However, such repeated comparable crises within a given organization remain the exception, and the principal focus of much of the post-crisis literature is on lessons which organizations can take from the experience of others. Some

scholars have expressed concern that organizations may over-interpret case studies when applying them to their own situation. For example, Elliott, Smith and McGuinness (2000) believe simplistic accounts of events that deny the complexity of causes of crises are an important factor in inhibiting real learning. Similarly Nystrom and Starbuck (1984) warn that managers often get into trouble by trying to follow prescriptions that have been formulated by someone else for different circumstances. "The simpler and more practical prescriptions sound," they say, "the more trust one puts in them and so the more danger they pose" (p. 59).

Yet it seems certain that high profile crises are likely to remain a continuing source for managerial and organizational learning.

The Fabled Twins of Crisis Management

There is no doubt that two of the best known and most analysed crises in western scholarship and the popular media are the 1982 Tylenol product tampering and the 1989 *Exxon Valdez* oil spill. And there is equally little doubt that no other two cases have been so prolifically linked as 'polar opposites' regarding what to do and what not to do in the face of a crisis. Yet in terms of organizational learning, there is a good argument that the apparent lessons from these contrasted examples may be simplistic and wrongheaded, and that the purportedly seminal contra-distinctions could mask deeper learning for contemporary management.

The broad facts of both incidents have been detailed in numerous texts and case analyses. In late September 1982 an unknown person spiked Tylenol capsules with cyanide, killing seven people in the Chicago area. Johnson and Johnson eventually recalled 31 million bottles of capsules and the adoption of tamper-resistant packaging was accelerated before the capsules were reintroduced and rapidly regained their pre-crisis sales. While the killer was never found, the company was widely acclaimed for its prompt voluntary recall and its commitment to openness with the public and the news media.

Almost seven years later, in March 1989, the tanker *Exxon Valdez* ran aground in Prince William Sound, spilling an estimated 38,800 tons of crude oil off Alaska, polluting hundreds of miles of coastline and severely damaging the local fishing industry. The oil giant was widely criticised for doing too little too late, and for attempting to assign blame elsewhere.

A leading comparative study of these two incidents (Pauly & Hutchison, 2005), found that within months of the *Exxon Valdez* crisis, news reporters had already begun linking Johnson and Johnson and Exxon in media stories about ensuing environmental, financial and health crises. Once established, the Tylenol-Valdez pairing became "a frame for every subsequent corporate catastrophe" (p. 242).

Pauly and Hutchison explored in detail the linking of the two crises in academic and popular reports, and how they quickly came to represent opposing examples of crisis management, with Johnson and Johnson positioned as the 'gold standard' against which 'deficient examples' like Exxon could be judged. However their analysis focuses primarily on the cases as 'moral fables' couched in terms of ethical leadership and does not fully address whether the popular conclusions are valid, or whether there are broader lessons to be learned.

Tylenol

The contrarian Washington consultant Eric Dezenhall (2004, p.15) has cynically asserted that many parties have a vested interest in perpetuating what he called the Tylenol legend. "The media love the story because it validates the canard that 'fessing up' is the best form of crisis management. Business schools worship the model because it's teachable and it had a happy ending for the manufacturer. Public relations firms use it to sell spin as the answer to industrial woes."

Many aspects of Johnson and Johnson's response are rightly praised, but objective analysis should avoid what Gorney (2002) described as 'mystification' of the Tylenol crisis, which she says has become almost mythical in both the mass media and public relations literature.

Gorney says using Tylenol as a model for ethical behaviour and good crisis communication presents three disturbing concerns; (a) that an apparent lack of case study creativity suggests that no other organization faced with a crisis of similar magnitude ever acted ethically or communicated effectively; (b) that attempting to compare disparate crises such as Tylenol and Exxon requires considerable suspension of disbelief; and, most importantly (c) that the variables between 1982 and today render many of the crisis management and crisis communications meaningless.

She concluded that the principal point at issue is whether the Tylenol model should be assumed as the most appropriate for all crises today, in particular for product recalls and, with it, the expectation that applying the model would have the same result as it did 25 years ago, when the communication, legal and public opinion environment was entirely different.

One of the actions for which Johnson and Johnson received most praise was its nationwide recall of Tylenol capsules, despite the fact that the cyanide deaths were confined to the Chicago area, and that it had no legal requirement to do so. However, the initial company recall after the fatalities was in fact limited to Chicago and extended only to certain batches of Tylenol Extra-Strength, the variety in which the poison was found. Meantime, as the story made international headlines, the USFDA had issued a national warning about all types of Tylenol and some major American retailers began their own recall before the company

did, taking Tylenol off their shelves across the country, as did some retailers in Europe, Asia and elsewhere (Foster, 2002). Johnson and Johnson extended their own recall to seven Midwestern states, but the full nationwide Tylenol recall was not implemented until five days after the first death, a decision reportedly taken only after a copycat case occurred in Northern California (Fearn-Banks, 2007).

Amid today's news media, public and regulatory expectations, it is difficult to conceive that seven deaths would *not* lead to an immediate national recall. Indeed, taking five days to initiate a recall in such circumstances would today more likely attract not praise for promptness but criticism for delay.

Another of the lauded actions in the Tylenol case followed company spokesman Lawrence Foster telling reporters that there was no cyanide present in the manufacturing plants. When he subsequently found that small amounts of cyanide were in fact present for required product testing, he was praised for volunteering this information to reporters to avoid suspicion of a cover-up and to protect both his and the company's reputation for honest and ethical behaviour.

The chronology of the case shows it was in fact the Associated Press which learned that cyanide was present in the plants and that Foster uncovered the truth only after the question had been raised by reporters (Fearn-Banks, 2007). Without diminishing the probity and promptness of Foster's action, it is clear that the company's 'voluntary correction' came only after the news media already had the story.

Exxon Valdez

The facts of the *Exxon Valdez* case are more straightforward and have been less obscured by 'mythology.' Much has been made of the comparison between the affable and available CEO James Burke of Johnson and Johnson and the rather remote CEO Lawrence Rawl of Exxon, though Pauly and Hutchison (2005) noted that Rawl's failure to display his emotion did not mean that he had no concern for the Alaskan people and the wilderness.

Moreover they concluded that scholarship on the Tylenol and *Exxon Valdez* crises takes its purpose as normative rather than descriptive, emphasizing how Exxon *should* have behaved, basing its judgment on retrospective inferences about the choices the company did or did not make. Indeed, they said neither case offers concrete evidence to explain the role that ethical considerations played in either company's strategy.

In this respect, a key issue in Exxon's response to the Alaskan oil spill is how and how soon the company apologised for the incident. Typical of the critical approach is the assertion by Olaniran and Williams (2001, p. 497) that Exxon "made no meaningful effort to communicate to the public that it was on top of the

situation and that efforts were under way to remedy the situation." Yet during the first public statement by an Exxon officer on the day of the spill (Exxon Shipping President Frank Iarossi), the company expressed regret and stated clearly that it assumed responsibility for the clean up. (The question of whether this statement should have been made by CEO Rawl rather than the senior official at the site, and whether Rawl should immediately have flown to the site, are separate issues. See for example Tyler, 1992). In subsequent paid advertising, press conferences and congressional hearings, Rawl himself repeatedly apologized for the disaster and took responsibility for the clean up (Lukaszewski & Gmeiner, 1993).

Tyler (1992, 1997) undertook one of the most exhaustive reviews of the Exxon communication response to the crisis and identified 11 specific communication practices on Exxon's part "that damaged the corporation's credibility and antagonized the public" (1992). She later conceded "it is, of course, entirely possible that no apology for Exxon's spill would have sufficed, that some acts are so offensive to those offended that no account could be effective, no matter how convincingly it was performed" (Tyler, 1997, p. 55).

As part of her analysis, Tyler suggested the proper lesson to be taken from the case was not Exxon's failure to communicate promptly and apologize, but the failure to apologise effectively. She said that by insisting that the disaster was an accident and that others had contributed to the damage caused by the spill, Exxon's statements were 'infelicitous' – that is, they were flawed 'equivocal pseudo-apologies' that were unacceptable and thus did not count as apologies at all.

What did Johnson and Johnson and Exxon learn?

Before proposing wider lessons to be taken by today's management from the Tylenol and *Exxon Valdez* cases of more than two decades ago, there is value in considering what lessons may have been learned by the companies themselves, based on their subsequent behaviour.

In the case of Johnson and Johnson, an incident almost four years later throws further light on the popular portrayal of the 1982 cyanide murders. In early February 1986 a woman in Westchester County, NY, died after taking a Tylenol capsule laced with cyanide, and a second bottle located on a nearby store shelf two days later was also found to be poisoned, even though the 'triple tamper resistant' safety seal was intact. While this renewed crisis has received less attention in the published literature, a full analysis and chronology (Benson, 1988) shows that the company heavily debated internally whether or not a recall was warranted. In the event, the day the crisis broke they recalled Tylenol from the shelves of stores within a three mile radius of the shop concerned. After the second contaminated bottle was found, Johnson and Johnson issued advice to consumers not to use Tylenol capsules until further notice, followed by an announcement that they would cease production of capsules and offered

consumers a refund. Finally, seven days after the initial death, they announced a nationwide recall. Benson has described in detail Johnson and Johnson's strategy to test the market and carefully position itself before eventually announcing the recall, and before the decision to phase out capsules in favour of tablets.

While Johnson and Johnson was once again publicly lauded for its response, Olaniran and Williams (2001) question why the company waited until after the second poisoning before replacing the demonstrably vulnerable capsules with tamper-proof solid product. They suggest the Tylenol manufacturer had become complacent with the fact that the public was sympathetic given that incident was due to sabotage that was no fault of Johnson and Johnson. Furthermore, they added: "it is uncertain whether, but quite possible that, Johnson and Johnson based its decision not to withdraw capsules from the market purely on financial reasons" (p. 495). If true, this would, at the very least, colour the much-vaunted 'gold standard' response to the first poisoning and the apparent management learning.

In a retrospective review, Mitroff and Anagnos (2000) claimed that, ironically, Johnson and Johnson's success meant they failed to learn the proper lessons from the Tylenol crisis. They said the company top management had stated that no prior special training would have helped them manage the poisonings better. Furthermore, they asserted that, 15 years later and contrary to most modern opinion, the company apparently *still* believed that no special crisis training was necessary for executives to prepare for a crisis.

For its part, Exxon did not need to wait as long for an opportunity to demonstrate whether or not it had taken any lessons from its iconic disaster. On New Year's Day 1990, less than 10 months after *Exxon Valdez* ran aground in Alaska, a 12-inch underground pipeline from an Exxon refinery near New York City ruptured and spilled heating oil into Arthur Kill, a narrow waterway between Staten Island and New Jersey, which was also an urban wildlife refuge. Exxon initially estimated the spill at 5,000 gallons, but it eventually proved to be 567,000 gallons, polluting the shores of two states and killing hundreds of rare wading birds.

Exxon CEO Lawrence Rawl – so recently criticised for failing to promptly go to Valdez – did not attend but allowed a parade of company spokespersons to provide confusing and contradictory statements. Meanwhile, New York Attorney-General Robert Abrams called it "a mini Alaska" (Yagoda, 1990), and five city, state and federal government agencies sued Exxon. They alleged that Exxon was not only responsible for the spill, but that its employees ignored three separate warnings from the pipeline's leak detection system and continued to pump oil into the pipeline for up to six hours after the leak was detected. Exxon, on the other hand, claimed that a foreign object ruptured the pipeline and denied responsibility for the spill (Max, 1993).

In the wake of the two spills (and a recent explosion at Exxon's heating oil refinery in Baton Rouge, Louisiana), a New York Times editorial castigated Exxon for what it described as "a case study in timidity, or worse, arrogance" and lamented "Exxon's cavalier disposition to attribute them to bad luck" ("Corporate Error – And Arrogance," 1990). CEO Rawl responded soon afterwards in a controversial interview with Time, stoutly denying the charge of arrogance. "As for Arthur Kill," he added, "that was an act of God, ripping that pipeline, but the way it was handled afterwards was a human error" (Behar, 1990, p. 62). Exxon spent a reported $15 million cleaning up the East Coast spill, and eventually reached a multi-million dollar settlement with the five government agencies affected.

By way of contrast with the barrage of criticism aimed at Exxon and its CEO, a few weeks after the Arthur Kill incident near New York, British Petroleum America on the West Coast demonstrated how to communicate effectively in such circumstances when their legendary CEO flew to the scene of a substantial oil spill (February 1990) off Huntingdon Beach, in Orange County, California. Even though the spill had come from a contract carrier and not a BP-owned tanker, the CEO told a press conference: "Our lawyers tell us it's not our fault. But we feel like it's our fault and we're going to act like it's our fault" (Sandman, 2002). Because the communication and subsequent clean-up were so well handled, the BP oil spill was soon virtually forgotten by the wider community and the news media (Woodyard, 1990).

What can be learned?

In terms of modern crisis management, what lessons can be learned from comparing *Exxon Valdez* and Tylenol? The simple juxtaposition of these two cases probably offers very little. Apart from the obvious fact that the media, regulatory and public expectation today is totally different, the two cases bear scant valid comparison.

The legal and fiduciary stakes alone mark a decisive distinction between the two, perhaps highlighting responsibilities beyond just media relations. The first Tylenol recall cost $100 million and the second recall and retooling cost $150 million (Shrivastava, Mitroff, Miller & Miglani, 1988). For its part, Exxon said at the time the Valdez cleanup, fines and compensation had cost the company $3.1 billion (Fearn-Banks, 2007). [1]

More importantly, the vital difference between the cases which makes comparison largely meaningless is that Johnson and Johnson was portrayed, and portrayed itself, as an innocent victim of a murderer, while there was never

[1] In June 2008 the US Supreme Court reduced the punitive damages to be paid by Exxon Mobil to $US507 million, about one tenth of the original amount awarded by an Alaskan jury in 1994. The court ruled that the company's action was 'reprehensible', but that they did not intend or deliberately cause the vessel to run aground

any doubt that Exxon caused the Alaskan spill and that it was responsible for the clean up. (For a more valid comparison, see for example a parallel study of the 1989 Valdez disaster and the 1988 Ashland oil spill into the Monongahela River. Goldberg & Harzog, 1996. This comparison is also examined in Kovoor-Misra & Nathan, 2000).

Indeed, Pauly and Hutchison (2005) have remarked that both Exxon and Johnson and Johnson arguably tried to do the right thing quickly, but that "one of them simply spoke more eloquently about its own response" (p. 238). Or as Center and Jackson (2003) suggested, Exxon did respond quickly, but concentrated more on emphasizing its clean up effort rather than addressing the public perception that they did not do enough, soon enough.

Perhaps the greatest limitation to learning and legitimate comparison between the cases is the distinction between the usual and the unusual. Marine oil spills, regrettably, are not at all rare.[2] By contrast the Tylenol case was so atypical as to be virtually unique. Tyler (1997) concluded: "Rarely are the company's hands so clean, and rarely is the corporation so patently a victim. Johnson and Johnson clearly handled a very difficult situation well, but the Tylenol case should not stand as the model for crisis communication" (p. 52).

Similarly Kaufmann, Kesner and Hazen (1994) said Johnson and Johnson was "almost uniquely able to pass itself off as the victim" and cited an unnamed journalist who even asserted that "Tylenol was as much a victim as the people who swallowed the cyanide-laced capsules" (p.36). They went on to conclude: "although it is pure conjecture, it is doubtful that the Tylenol product would have made as successful a recovery if the poisonings were caused by inadequacies in the manufacturing process, even if the corporation made the same disclosure decisions" (Kaufmann et al. 1994, p. 36).

A parallel contemporaneous example – where the company concerned attempted to present itself as a victim, and where consecutive recalls were differently handled – is the case of Gerber baby food. In September 1984, two years after the first Tylenol poisoning, Gerber recalled over half a million jars after fragments of glass were found. The company later claimed this was not a manufacturing fault but resulted from rough handling in transit. In March 1986, just days after the second Tylenol poisoning, Gerber faced hundreds of unsubstantiated and probably malicious claims about glass fragments. The FDA found nothing to justify a recall, but comparisons with the Tylenol case were inevitable, exemplified by the *Advertising Age* headline: Gerber Ignores 'Tylenol textbook' (Strand, 1986).

[2] Marine oil spills are catalogued by the International Tanker Owners Pollution Federation (www.itopf.com). On their list of major spills since 1967, *Exxon Valdez* is only the 35th largest.

On this second occasion, Gerber stubbornly refused a recall, even launching a $150 million suit against the State of Maryland for banning one of its products. In a defiant interview with the New York Times, new Gerber CEO William McKinley demanded: "Why do you throw us in with Tylenol? There's no relation whatever." (Barron, 1986). Indeed, he went further and asserted that the 1984 recall had been unwarranted, that the company had over-reacted, and a recall "just fanned the fire." Many years later the company's former Director of Corporate Communications wrote: "Regardless of what you may have read or heard, the 1986 baby food glass scare was *not* the 1986 Tylenol capsule poisoning revisited. The only *real* connection between capsules and baby food was in the timing" (Lovejoy, 1993, p. 175).

Mitroff and Anagnos (2000) argue that one of the important lessons to be taken from events at this time was that prior to the Tylenol poisonings, the number of annual threats against American food and pharmaceutical companies ranged in the hundreds. Afterwards, the number jumped to the thousands. In addition there is now also an established literature on product safety crises and recalls.

A lesser known feature of the Tylenol story, which merits consideration today, relates to the identification of the company at the early stages of the crisis. While the 1982 case is frequently cited as a standard for open and proactive communication, a number of scholars have remarked that as the initial drama unfolded there was an apparent attempt to attribute the recall to McNeil Consumer Products Company, the subsidiary which manufactured Tylenol. Fearn-Banks (2007) noted that most early announcements and news reports provided all mention of the company as McNeil, "not as familiar a name to consumers as Johnson and Johnson" (p. 64). In fact some of the advertising telling consumers how to exchange their Tylenol capsules for a refund or tablets was attributed to neither Johnson and Johnson or McNeil, but to "the makers of Tylenol." The concept of a parent company using a subsidiary identity to protect its name during a crisis, or obscuring its identity entirely, was effectively demonstrated, though this is not usually part of the 'fable'.

The remaining critical factor in the Tylenol case relates to the claimed effectiveness of the product recall and the subsequent rapid market recovery. While the first Tylenol recall was innovative at the time, such recalls have become extraordinarily commonplace.[3] Yet, apart from relatively infrequent extortion incidents, the Tylenol case is unusual in that not only was Tylenol the victim but the product itself was never accused of any fault. Accordingly, the company was not required to defend any wrongdoing, and its vulnerability over delay in introducing tamper proof caplets was diffused by the tragic circumstances of the poisonings and by a more 'product friendly' news media of

[3] In the United States alone the U.S. Consumer Product Safety Commission (www.cpsc.gov) reported in 2007 a record 472 recalls, totaling 110 million production units.

the time, which gave Johnson and Johnson "unchallenged media opportunities to tell its own story and promote its new packaging" (Gorney, 2002, p. 22).

Because of these circumstances, and the ready availability of alternative packaging, Berg and Robb went so far as to suggest that "the situation, contrary to popular belief, did not constitute a formidable public relations problem" (1992, p. 102). They concluded: "The decisions that were made by the company do not reflect the levels of wisdom, candour and selflessness which have often been attributed to them. The case is certainly one that those interested in crisis management should study. It is not one, however, that establishes a standard of excellence by which all other crisis management efforts can be evaluated" (p. 105).

An opposite view was expressed by Albert Tortorella, a consultant to Johnson and Johnson during the crisis, who wrote a letter to the Editor of *USA Today* more than two decades later asserting that executives still saw Johnson and Johnson's success as a template by which their behavior would be judged. He said enlightened senior management were "fortunate that almost a quarter of a century later Tylenol's experience and lessons learned are a talisman of hope for every chief executive who unexpectedly is forced to peer into the abyss" (Tortorella, 2004, p.12).

Both of these polarised positions may be overstated. The real significance of the 1982 Tylenol case is that, at the time, the concept of major recalls and a highly proactive media strategy in the face of a crisis were relatively new. And it is widely believed that the case marked the beginning of organizational crisis management as a discipline in its own right (for example Mitroff, 2002; Seymour & Moore, 2005). In this respect its ultimate value is not whether it creates a template to be followed today, but that it began a new and sustained concept of management proactivity. Furthermore, Sellnow and Seeger (2001) believe that examination of the Tylenol and Valdez cases, among others, began to reposition crisis communication as an ongoing process rather than a one-time strategic response.

With regard to *Exxon Valdez*, that event can legitimately be presented as a case study of poor crisis management and the impact of such failure (In the space of a year the company fell from 6th on the Fortune list of most admired companies to 110th. Kaufmann et al. 1994). However, many other companies both before and since have displayed equal or even greater incompetence, and the question must be asked whether the case merits being described as paradigmatic, or was it just highly publicized.

In the months immediately after the Alaskan oil-spill disaster, and before the retrospective analysis and rewriting of history which continue to this day, more than 200 US and Canadian executives were surveyed about their impression of the handling of the spill and their views of lessons for other

organizations (Lukaszewski, 1989). In summary the key lessons expressed by this broad cross-section of executives for their own organizations were that public perceptions matter more than facts; that an instant apology-fact-action plan would have put more people on Exxon's side; and that mistakes which appear unnecessary can have a powerful negative effect – for a long time.

For other oil companies, some of the longer-lasting lessons taken from the Valdez incident related to operations rather than crisis management, such as not to use single-hulled vessels in environmentally sensitive enclosed waters, to ensure proper training for crew and pilots, and not to identify the owning company in the names of oil tankers. (*Exxon Valdez* herself was later renamed *Sea River Mediterranean*.)

The Future Role of Iconic Cases

The central question which arises in this paper is whether these and other iconic cases before the advent of the internet and 24-hour TV news– such as Three Mile Island (1979), Bhopal (1984), Chernobyl (1986) and Challenger (1986) – help a fuller understanding of crisis management practice today. Or whether they cast a shadow so long as to inhibit the exploration and assessment of other more recent and possibly more relevant cases. For example, it has been argued (Pauly & Hutchison, 2005) that the joint Tylenol/*Exxon Valdez* 'fable' narrows our understanding of the ethical dilemmas confronting public relations and that it controls the range of debate and trims its stakes by excluding more troubling and morally problematic corporate behaviours.

Furthermore, deeper examination of the Tylenol and *Exxon Valdez* incidents indicates how easy it is to be led to wrong or inappropriate lessons from highly exposed cases. As literary fables are fictitious or legendary tales intended to convey a moral, so too some of the iconic crisis cases have become little more than shorthand references, or Burkian 'representative anecdotes,' intended to encapsulate a supposed maxim of crisis management or crisis communication.

't Hart, Heyse and Boin (2001) have urged that scholars and practitioners need to move away from traditional preoccupations with "digging up more than anybody wants to know about single, history making cases" (p. 186). They propose instead systematic efforts and sophisticated comparative research comparing and contrasting morphologically similar crises; different national and international institutions, and practices of crisis management; and different transnational crisis management operations in various policy sectors.

Only in this way can managers move beyond mystification of past crisis icons, even when their direct relevance to modern practice has long since passed. The challenge for current managers and scholars is to identify and analyze the 'new icons' from today's case studies which can provide the basis for genuine learning.

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Crisis management requires more than an apologetic press release or a CEO's disingenuous appearance on CNN. News goes viral in a flash. Companies must be ready to respond to disasters swiftly and decisively, using all platforms to communicate with the public. Most importantly, companies that make mistakes must sincerely accept responsibility for their actions -- not distance themselves from them. There's no cure-all method to remedy company crises, but there are lessons to be learned from past successes. Here are examples of nine companies that saved themselves -- and their precious The helping or hindering is not the result of the computer technology, but how the technology is used. In other words, how does the technology design support the instructional design, and how do both of them support the learning outcome objectives? The way the technology is used has the potential to interest and motivate students, resulting in better outcomes...or to frustrate, bore, or demotivate students, resulting in failure to achieve learning outcomes. 1 Recommendation. 12th Dec, 2016. Studying past crises is accepted as important for managerial and organizational learning, yet experience suggests there has been little improvement over time in overall crisis response. This paper considers the reasons for this failure and revisits some iconic organizational crises (including Tylenol and Exxon Valdez) to question if they merit the attention they receive. The paper also explores the way in which misleading or inappropriate lessons can easily be drawn from such cases and asks how relevant they are today. Moreover, does a persistent focus on a very limited number of historic case...