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**ORGANISATIONAL VALUES  
IN THE FRAMEWORK  
OF CRITICAL INCIDENTS:  
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FOR VALUES-BASED  
SOLUTIONS?**

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# ORGANISATIONAL VALUES IN THE FRAMEWORK OF CRITICAL INCIDENTS: WHAT ACCOUNTS FOR VALUES-BASED SOLUTIONS?

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## Abstract

According to different estimations, nearly 50% of organisations have defined their core values in the wake of their leaders' declaration that they would treat values as their primary guide in daily activities. In this article we argue that managing values might in reality be far more complex. Based on 98 cases, this paper brings forth the most common practices that account for either alignment or discrepancies between the outcomes of everyday work situations and the sets of organisational values. Our study reveals a host of reasons explaining consistent behaviour as well as misalignment. The results suggest that, regardless of the type of critical incidents, the cases where solutions to particular incidents did not call for violation of organisational values were typically associated with the managerial level of judgement and, accordingly, commitment from the top. Employees' commitment to values also plays a significant role, but contradictory organisational values or ill-defined allocation of resources may severely distort it.

**Keywords:** organisational values, managing values

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# INTRODUCTION

Modern organisations find it useful to define their core values that would guide every employee's actions if neither the procedures nor immediate coaching are in place. This is the motivation behind the emergence of management by values, which in essence means defining the values of the organisation, communicating them to all relevant constituencies, and incorporating the values into all organisational activities. However, even the best of organisational values will be eroded if the degree to which the values are implemented varies for different situations or persons involved. The weakest point in management by values is the vulnerability of the concept due to toleration of deviations from the agreed values. On the other hand, given the variety of organisational decisions, management by values is far from being a one-off campaign; instead, it proves to be a continuous challenge.

This paper attempts to explore how management by values works in everyday practice. **The aim of the study** is to identify the factors contributing to congruency between organisational values and the way critical situations are handled. The respective research tasks are as follows:

- a) giving a brief overview of the theory of organisational values;
- b) collecting empirical evidence of organisational values, critical incidents and their solutions;
- c) analysing different types of critical incidents and their contribution to the positive or negative outcome;
- d) analysing the reasons associated with certain outcomes.

## 1. Literature Overview

Organisational values are often discussed in the context of business ethics. However, one should not confuse organisational values and adoption of codes of ethics. A body of literature is available focussing on the relationship between ethical behaviour and the presence of codes of ethics, and making critical remarks about many cases (Malloy, Agarwal, 2003, p. 241, Pater and Van Gils, 2003, p. 768, Griseri, 1998, pp. 161-166, Solomon, 1999, pp. 51-54). On the other hand, there are authors (Hoffmann and Driscoll, 2000, pp. 77-78) who do not share this entirely pessimistic approach regarding codes. Yet these mixed results have undermined the popularity of ethical codes in organisations. It is generally recognised that in difficult situations people will resort to everyday practices and behaviours rather than official documents. So, in principle, this gap might be filled by shared organisational values and thus management by values has emerged.

Although all organisational members are “managers” in the sense of “managing by values”, the role of executive officers is claimed to be crucial (Schein, 1992, p. pp. 240-245, Badaracco, 1998, Pater, Van Gils, 2003, p. 769, Lencioni, 2002, p. 116, Griseri, 1998, p. 203, Solomon, 1999, p. 54, Edmondson, Cha, 2002, pp. 18-19). Whatever decisions the leaders make, they will set an example to the people around them and will influence the behaviour of others in the group. This is similar to what Schein (1992) calls “managing the unmanageable” or “explaining the unexplainable”, by stating that: the “cultural process in the organisation tends to occur around critical events in the organisation’s history” (p. 89). Griseri (1998) calls it “incidental learning” (p. 195), which takes place unconsciously, even in the least learning-like situations. Those situations (critical incidents in our study) test the espoused values and if the involved person’s actual behaviour does not reinforce them, there is room for distortion and confusion. Experiments have shown that organisational philosophy or policies are more strongly believed in if there is a story to support it (Martin,



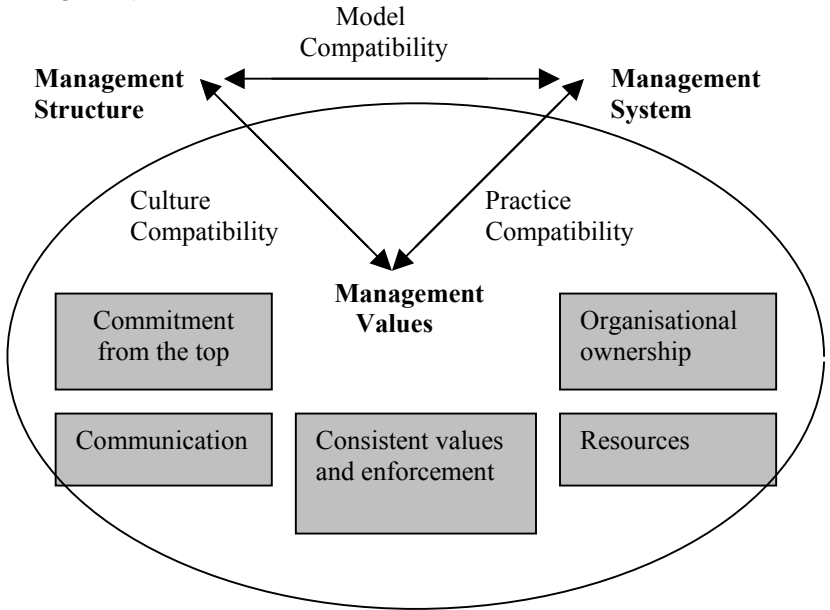
Powers, 1991, pp. 263–264). In this case, values are verbally espoused and managers are encouraged to express organisational values directly via speeches, presentations, etc. It should be noted, however, that more sceptical employees might consider this approach alone as organisational propaganda. In their study of the ways in which the CEO's personal values are delivered to the followers, Liu (2004, p. 18) surprisingly found that even if the CEO uses a policy-oriented approach, i.e. routine-based system-driven norms and regulations, to express his/her values, s/he will achieve significant commitment from his/her followers. Indeed, the solutions to dilemmas or ethically difficult situations often rely on the existing systems and institutional incentive mechanisms. An important implication is that employees trust those mechanisms at least as much as explicit leaders' values.

A similar message is conveyed by Padaki (2002, pp. 322–324) who finds that dilemmas or conflicts occur due to inconsistencies in the organisation's model compatibility, culture compatibility or practice compatibility. Model compatibility involves assumptions about what an organisation is, how it functions and how to make it work. It is essential that the management structure and management system should convey a similar view of the nature of the organisation. Inconsistencies in culture compatibility occur when espoused management values and professing of certain patterns of conduct vary along the management structure. Practice compatibility is jeopardised when value premises in the management system are in conflict with the prevailing orientations and norms of conduct.

The current paper concentrates on practice and culture compatibility, because in the context of management by values the central feature is the values that the management (unconsciously) imposes on the organisation. What are the factors for explaining practice and culture compatibility in organisations?

Driscoll and Hoffmann (2000, p. 7) identify ten key elements necessary for successful development of any corporate values initiative. Self-assessment, codes of ethics, training, audits and

evaluations, revision and reform are mentioned as the relevant tools. But it is the remaining five factors that deserve also some elaboration, because, in our view, these elements are central to making organisational values work in everyday practice (see Figure 1):



**Figure 1.** Five factors of culture and practice compatibility (modification of the three-way compatibility model by Padaki (2002), p. 322).

**Commitment from the top:** as already discussed in connection with the role of management, long-term-values-based management can only be successful if the most senior levels of management are committed to the agreed values and demonstrate them in their decisions and actions.

**Communication:** it is important to have a two-way communication process in place in order to transmit organisational values to all organisational members from their very first day with the organisation.

**Resources:** in addition to clear values, practical mechanisms would further support and ensure an effective application of values in daily decision-making processes. Under this category belong organisational strategy, procedures, structure, priorities reflected in the budget, etc.

**Organisational Ownership:** this can be interpreted as full involvement and support of everyone throughout the organisation. Values-based management becomes pointless if employees do not regard the values as important and true. In our study, this category is mostly related to the cases where an employee was to act in an ambiguous situation or had to fulfil a task differing from his/her routine assignments.

**Consistent values and enforcement:** the consistency of organisational values is by no means something that occurs naturally all by itself. Organisations are persistently torn between conflicting interests and objectives (e.g. lowering production costs *versus* providing high-quality products), therefore it is not a rare occasion that the values designed to guide an employee appear to be in conflict with each other. Hence, in trying to behave according to one particular value, one inevitably violates the other. Another factor is consistent enforcement of values, i.e. it is not in the spirit of values-based management to apply values occasionally, whenever suitable; instead, they must be enforced systematically, even in relatively aversive situations.

The five factors above constitute the reasons for critical incidents' outcomes in the empirical part of the current paper.

## 2. Method and Sample

To analyse the management of values through critical incidents, the authors of the current paper gathered 121 cases from Estonian organisations. The respondents were undergraduate students who attended the course "Organisational Behaviour" between November 2003 and February 2004 in three academic

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institutions: the University of Tartu, the Tartu University Narva College, and the Defence College. All the students were working for some organisation (including the university itself) at the time of the course or had working experience from the past. Out of the 121 respondents 71 were male and 50 were female.

We considered the respondents as a type of observer (cf. Victor and Cullen, 1988, for example) assessing organisational values and critical incidents. That is, our organisational members were not asked to report on their own behaviour and values, but rather on the practices and procedures that they perceived to exist in their organisations. Asking the respondents to describe a critical incident and its outcome, the authors of the article applied the concept of “event management” suggested by Smith *et al* (1988) for analysing organisational behaviour. According to this approach, events are all those elements in an organisational setting, which are given meaning by any member of the organisation.

As a method of analysis, critical incidents are widely used in the studies of culture, norms, attitudes (Milliman *et. al*, 2002, Fink, Meierewert, 2004, van Veen *et. al*, 2003), customer satisfaction (Sõstra, Vadi, 2001), learning and professional development (Tirri, Koro-Ljungberg, 2002), etc. We also believe that an analysis of particular events and behaviours contributes greatly to research into organisational culture and values alongside abstract concepts characterising the organisation.

However, one distinct note should be made about the use of critical incidents as a method. Contrary to many authors who pre-defined a set of hypothetical critical incidents before asking their respondents, we were not prescriptive about the kinds of incident. Thus we received the descriptions of a variety of situations ranging from routine occasions like dealing with a complaint by a customer to much more complicated situations like, for instance, losing the market share due to expected unfavourable regulations by the government. Based on Smith and Peterson’s approach, then, the critical incidents were divided into four categories: human resource management,

production or service quality, improvement of work-procedures, and cooperation.

Given this framework, we categorised each case independently and compared the results. In case of differing opinions, we re-examined the case together and reached a consensus. The aim of this process was to minimise personal subjectivity in classifying the cases. All in all, out of 121 cases 98 were accepted by the authors as having clear-cut characteristics to be classified in the given framework. Several cases that were left aside failed to represent a distinguishable incident. The results of inter-judge classification are presented in Tables 1 and 2; an example of a critical incident is given in Annex 1.

**Table 1**

**Statistics of Critical Incidents' Outcomes by Type of Incidents**

| <b>Type of Critical Incidents</b> |           | <b>Outcomes in the Light of Values</b> |           |          |
|-----------------------------------|-----------|--|-----------|----------|
|                                   |           | Positive                               | Negative  | Partial  |
| Human Resource                    | 32        | 12                                     | 19        | 1        |
| Quality                           | 29        | 18                                     | 6         | 5        |
| Co-operation                      | 20        | 8                                      | 12        | –        |
| Procedures                        | 17        | 11                                     | 4         | 2        |
| <b>Total</b>                      | <b>98</b> | <b>49</b>                              | <b>41</b> | <b>8</b> |

### ***Type of critical incident***

As appears from Table 1, critical incidents are most frequently associated either with personnel issues or quality-related events. A typical human resource issue was an employee's dishonesty or behaviour deviating from accepted norms. As a rule, the quality-related incidents involved the handling of customer-relationship, but in some instances, procedures or company policy features were intermingled with it. The incidents evolving from co-operation problems involved a new leader, typically a change management situation, or a direct conflict

between the members of the organisation. Procedures-related critical incident were assigned to the cases where the usual functioning of the organisation had brought along unintentional, sometimes even dangerous results (ignoring safety requirements, careless financial management, etc) or the established procedure was questionable in a specific circumstance. In several procedure-related incidents, there was a dramatic change in the external environment (legislation change, loss of a big customer, etc) that made the organisation reconsider the whole strategy used.

**Table 2**

**Statistics of Critical Incidents Outcomes by Reasons**

| <b>Reasons for the Solution</b>      |            | <b>Outcomes in the Light of Values</b> |           |          |
|--------------------------------------|------------|--|-----------|----------|
|                                      |            | Positive                               | Negative  | Partial  |
| Organisational Ownership             | 38         | 19                                     | 18        | 1        |
| Resources                            | 35         | 16                                     | 19        | –        |
| Commitment from the Top              | 31         | 25                                     | 6         | –        |
| Communication                        | 15         | 8                                      | 7         | –        |
| Consistent Standards and Enforcement | 11         | 1                                      | 3         | 7        |
| <b>Total</b>                         | <b>130</b> | <b>69</b>                              | <b>53</b> | <b>8</b> |

### *Outcomes in the light of values*

The critical incidents either found solutions in accordance with organisational values (positive outcome), or were not supported by them (negative outcome). In addition, a partial solution was implemented in eight cases and, as shown by Table 2, the reason for this was mainly inconsistent values. In statistical analysis, a partial result is treated as a negative one. As can be seen from Table 1, half of the critical incidents found a positive solution and in the following statistical analysis we first try to

find whether certain types of incidents have a higher probability of leading to a positive outcome.

### ***Reasons behind the solution***

Based on Driscoll and Hoffman, the reasons that led to a positive or negative outcome of a critical incident were divided into five factors as depicted in Figure 1. As could be expected, many incidents revealed more than one appropriate factor being the cause for the solution (see Table 2). For instance, communication was hardly the sole factor for any incident. If present, it always accompanied one of the remaining four factors. The same was true about the second most frequent reason – resources. Therefore the number of cases (98) and overall sum of reasons (130) do not match. However, it is worth mentioning that in every critical incident that qualified for the sample, the outcome could be explained by at least one of the five factors suggested by Driscoll and Hoffmann.

Table 2 reveals that more than a third of the cases had the outcome that could be explained by organisational ownership. Consistent standards and enforcement as a cause for the outcome could be assigned to only 11 cases, and according to the table, there is a direct link to the cases that resulted in a partial solution in the light of organisational values – those incidents were characterised by inconsistent standards in the first place<sup>4</sup>.

### ***Control Variables***

We also classified the cases on the basis of general organisational features – the public/private sector and size of the organisation – as well as the level of judgement in critical

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<sup>4</sup> Some examples of inconsistent standards are: being “customer-oriented”, but having a “good reputation” (in situations where the customer requests unethical service), being “professional” (meeting the customer’s needs, however long it takes) and “operational” (responding to requests as quickly as possible) at the same time, and, more typically, being “performance-oriented”, while “every client is important to us”.

incident<sup>5</sup>. In our statistical analysis, 95 cases could be used, because 3 cases did not specify the size of the organisation (for description of the sample see Table 3).

**Table 3**

**General statistics of the control variables**

| Sector       |           |            | Size of the Organisations     |           |            | Level of Judgement in a Critical Incident |           |            |
|--------------|-----------|------------|-------------------------------|-----------|------------|---|-----------|------------|
| Category     | No        | %          | Category                      | No        | %          | Category                                  | No        | %          |
| Private      | 66        | 67%        | Small (below 50 employees)    | 34        | 35%        | Management                                | 47        | 48%        |
| Public       | 32        | 33%        | Medium (51 – 249 employees)   | 15        | 15%        | Employee                                  | 51        | 52%        |
|              |           |            | Big (more than 249 employees) | 46        | 47%        |   |           |            |
|              |           |            | Not specified                 | 3         | 3%         |   |           |            |
| <b>Total</b> | <b>98</b> | <b>100</b> | <b>Total</b>                  | <b>98</b> | <b>100</b> | <b>Total</b>                              | <b>98</b> | <b>100</b> |

### 3. Discussion of the Results

There were two models we tested to shed light on our research questions. The models were tested with STATA software. The first probit-model had each incident's outcome as a dependent variable (1 if the outcome was values-based, and 0 if the outcome was value-breaching) and types of the incidents as explanatory ones. In addition, control variables on the sector, size and level of decision-making were included, but only one remained statistically significant (see Annex 2). The results are presented in Table 4.

<sup>5</sup> The inter-judge method was not needed with this research task



**Table 4**  
**Results for the type of incidents predicting a positive outcome**

|                         |                 |                 |             |              |                          |
|-------------------------|-----------------|-----------------|-------------|--------------|--------------------------|
| Probit estimates        | Number of obs = |                 |             |              | 98                       |
|                         | Wald chi2(4) =  |                 |             |              | 15.74                    |
|                         | Prob > chi2 =   |                 |             |              | 0.0034                   |
| Log pseudo-likelihood = | -58.96064       |                 |             |              | 0.1320                   |
| Robust                  |                 |                 |             |              |                          |
|                         | C.I. ]          |                 |             |              |                          |
| positive                | dF/dx           | Std. Err.       | z           | P>z          | x-bar [ 95%              |
| hr*                     | -.2490264       | .148713         | -1.60       | 0.109        | .326531 - .540498        |
| q*                      | .0972534        | .1743879        | 0.55        | 0.580        | .295918 - .244541        |
| c*                      | -.2303642       | .1632212        | -1.33       | 0.184        | .204082 .550272          |
| <b>manager*</b>         | <b>.3655241</b> | <b>.1028799</b> | <b>3.29</b> | <b>0.001</b> | <b>.479592 - .163883</b> |
|                         |                 |                 |             |              | <b>.042446</b>           |
|                         |                 |                 |             |              | <b>.439047</b>           |
|                         |                 |                 |             |              | <b>.089543</b>           |
|                         |                 |                 |             |              | <b>.567165</b>           |

Note: hr\* – human-resources-related incidents, q\* – quality-related incidents, c\* – co-operation-related incidents, manager\* – decision-making at managerial level.

From the table above, where co-operation-related incidents are taken as the basis for comparing the results, it appears that the types of incidents are statistically insignificant in predicting the outcome. On theoretical grounds it should be no surprise. What this result confirms is that values are equally embodied in all types of incidents and whether they are violated or not depends on other factors than the specifics of the situation.

On the control-variable side, neither size of the organisation nor sector could contribute to predicting the outcome for critical incidents in statistically significant measure. In fact, the only significant variable in the model was the level of judgement. There is 36% bigger likelihood for managers to solve critical incidents in a way that is perceived to be in line with organisational values. This result has at least three interpretations.

Firstly, it once again brings forth the existing relationship between the managerial and organisational values, so often assumed in theory. The formation of an organisation's values is first and foremost related to its leaders' values and so it is natural for the latter to act according to organisational values even in most controversial situations.

Secondly, the result might imply that leaders care more about organisational values than do their subordinates. Even though organisational values have evolved over time and have been influenced by many members of the organisation, it is ultimately the manager rather than employee who tends to hold on to the values when facing a critical incident. However, whether this is, indeed, true needs further analysis, because it has neither been theoretically established nor confirmed by earlier empirical studies. On the contrary, recent world-famous scandals (Enron, WorldCom, Scandia) tell us about the reverse situation: it is the management, not ordinary employees, who fail to follow and promote organisational values. Thirdly, as demonstrated by Cha (2004), there is a tendency for employees to regard the activities by management as aligning organisational values, whereas the same action by a co-worker might be considered as value breaching. This mechanism may have

worked also in our study: it might be claimed that due to relatively ambiguous organisational values the respondents picked the values that were in some way reflected in their managers' actions, rather than comparing those actions with hypothetical standards.

Next, a model for negative outcome as a dependent variable was related to five factors (see Annex 3). The results are presented in Table 5.

Taking "communication" as the reference variable among the five factors to compare the results with (it was equally present in positive as well as negative cases), there are two clearly significant variables: organisational ownership and commitment from the top. When compared to communication, both factors gave 47% bigger likelihood for the critical incident to find a values-based solution.

As mentioned earlier, organisational ownership is mostly related to employee-level behaviour in our study. It is slightly surprising that this variable strongly influenced the positive outcomes, because this factor equally explained positive and negative outcomes (see Table 2). Although the negative cases often had lack of organisational ownership as one explanation, it was probably counterbalanced by other accompanying factors, e.g., ill allocation of resources (performance appraisal that had little or nothing to do with values, formal procedures to be followed, etc) or lack of communication. In positive cases, on the other hand, belief in and commitment to organisational values alone seemed to explain the outcome.

**Table 5**  
**Results for the reasons predicting a negative outcome**

| Probit estimates                   | Number of obs    |                 |              |              | 98                       |
|------------------------------------|------------------|-----------------|--------------|--------------|--------------------------|
| Wald chi2(5)                       |                  |                 |              |              | = 26.20                  |
| Prob > chi2                        |                  |                 |              |              | = 0.0001                 |
| Log pseudo-likelihood = -51.937124 | Pseudo R2        |                 |              |              | = 0.2354                 |
| Robust                             |                  |                 |              |              |                          |
| negative                           | dF/dx            | Std. Err.       | z            | P>z          | x-bar [ 95% C.I. ]       |
| <b>CFTop*</b>                      | <b>-.4751952</b> | <b>.1588884</b> | <b>-2.49</b> | <b>0.013</b> | <b>.316327 - .786611</b> |
| <b>OrgOwn*</b>                     | <b>-.4692902</b> | <b>.1532213</b> | <b>-2.65</b> | <b>0.008</b> | <b>.387755 - .769598</b> |
| ConSt*                             | .2821318         | .2078088        | 1.16         | 0.246        | .112245 - .125166        |
| Res*                               | -.1162099        | .1380214        | -0.84        | 0.403        | .357143 - .386727        |
| <b>manager*</b>                    | <b>-.355674</b>  | <b>.1692278</b> | <b>-1.96</b> | <b>0.050</b> | <b>.479592 - .687354</b> |
|                                    |                  |                 |              |              | <b>-.023994</b>          |

Note: CFTop\* – Commitment from the Top, OrgOwn\* – Organisational Ownership, Res\* – Resources, ConSt\* – Consistent Standards and Enforcement, manager\* – decision-making at managerial level

This result shows the importance of organisational ownership for successful values-based management, but it also indicates how easy it is to destroy it by introducing management systems that are not led by values.

Since commitment from the top and management-level decisions go hand in hand, the estimation of the latter's significance is somewhat lower than previously, being exactly within the limit of 95% probability.

To conclude, the models seem to indicate the following: managers are the key people to ensure that employees would perceive organisational decisions and actions to be consistent with organisational values. Via managers' personal commitment to the established values and their corresponding behaviour organisational ownership by other members will follow, unless there are mechanisms in place to distort employees' involvement in values. It should be noted, however, that creating those mechanisms is in the hands of managers themselves.

## **4. Limitations**

- 1) The authors of the paper fully acknowledge that making generalisations on the basis of 98 cases is, however tempting, an erroneous approach. We therefore aim to enlarge our sample to test the robustness of the results.
- 2) Classification of the incidents is a subtle area in many instances. Subjectivity is heavily involved in this process; even though we hoped that an inter-judge method would somewhat decrease its extent.
- 3) Using the members of the organisation as the only source to report on their organisational values might raise the question about whether the reported values are actually in place in the organisation. Although this question points to one of the potential limitations of this study, the authors of the article do not consider it to be fatal to the results. According to Weick (1979, pp. 147–204), people

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are continuously trying to explain the world through historical sense making, which is the basis for the “selection process” (i.e. what combinations of information are seen as meaningful). The selection process works through previous experiences and events that have taken place in reality. Thus, people usually see in the present what they have seen before.

- 4) Most organisations in the sample had not explicitly declared their application of value-based management. It simply was not the criterion for selecting respondents. Hence, the incidents presented were perhaps less inclined to be managed according to values and therefore there was a chance for biased representation of negative outcomes in the sample. In the authors’ view, however, formally launched management by values would increase the members’ attention paid to managing events in the organisation, after which negative outcomes would be even more eagerly detected. In fact, in this study the ambiguous organisational values were the likely reason for the tendency to report positive cases. Organisational values were derived from management reactions to critical incidents.

## CONCLUSIONS

The current paper shows that the following statements about managing by values in everyday practice seem to hold:

- 1) On the basis of 98 cases drawn from Estonian organisations, critical incidents were reported that were either human- resources-related, procedures-related, co-operation-related or quality-related situations. The authors tested in the first place whether any specific type could predict values-based solutions. Yet, according to the probit model, none of the incidents of a particular type had more potential to be managed according to values than the incidents of other types.
- 2) It appeared that values-based solutions to critical incidents are associated with managers who are personally committed to the established values. Also, “organisational ownership” by employees is a significant factor, which, if present, is likely to lead to solutions that are perceived to be consistent with organisational values.
- 3) Organisational ownership will not be reached in case there are systems in place that not only fail to enforce values, but also seriously distort employees’ involvement in them. The authors of this paper therefore support the idea that organisational values need to be integrated into every employee-related process (Lencioni, 2002, p. 117), otherwise one cannot expect the members of the organisation to take values seriously enough to remember them in critical situations.
- 4) Values-based solutions also depend on organisational values themselves: in the current sample there were some cases in which a value-breaching outcome to a critical incident was predictable because of inconsistent values. Consequently, every manager trying to introduce management by values should first think about the consistency

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of the existing values before analysing management systems and processes.

To sum up, the current paper claims that organisational values are most likely incorporated into the ways in which critical incidents are handled if managers are involved in finding solutions to critical incidents. Thus we confirm the idea that employees draw conclusions about organisational values on the basis of their managers' behaviour.



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## KOKKUVÕTE

### **Organisatsiooni väärtused kriitiliste intsidentide raamistikus: väärtuspõhiste lahenduste tegurid**

Juhid, kes lähtuvad organisatsiooni igapäevatoos selgetest väärtustest, on hinnatud kõigjal. See on ilmselt ka põhjuseks, miks organisatsioonid tegelevad üha rohkem oma väärtuste defineerimise ja nn. väärtusjuhtimisega. Paraku piirdub väärtusjuhtimine tihti vaid väärtuste sõnastamisega. Käesolevas artiklis analüüsivad autorid väärtuste järgimist ja mittejärgimist organisatsiooni igapäevaelus ettetulevate kriitiliste situatsioonide kaudu. Artikli eesmärgiks oli välja selgitada, millised faktorid mõjutavad organisatsiooni väärtustega kooskõlalisi lahendusi kriitilistele intsidentidele. Autorid kogusid kirjeldusi organisatsiooni väärtuste ja kriitiliste juhtumite kohta 121-lt töötavalt tudengilt. Subjektiivsuse vähendamise eesmärgil analüüsisid nad juhtumeid topeltklassifitseerimise meetodil. Selle tulemusena jäi lõplikusse valimisse 98 juhtumit.

Esimesena analüüsiiti, kas mõnda spetsiifilist juhtumit tüüpi lahendatakse suurema tõenäosusega organisatsiooni väärtustest lähtuvalt. Juhtumite klassifitseerimise aluseks võeti seejuures Smith' *et al* poolt pakutud jaotus: inimressursiga, kvaliteediga, protseduuridega ja koostööga seotud juhtumid. Kasutati probit mudelit, kus sõltuvaks muutujaks oli kriitilise intsidendi lahendus (1, kui see oli väärtustega kooskõlas ja 0, kui väärtustega vastuolus) ning sõltumatuteks muutujateks juhtumit tüüp. Tulemuseks antud valimi põhjal oli, et situatsioonitüüp ei suuda statistiliselt usaldusväärsuselt ennustada, kas intsident laheneb väärtustega kooskõlalisel või mitte. Mudelis testiti ka kontrollmuutujaid – organisatsiooni suurus, sektor ja juhtumit otsustustasand. Olulise kontrollmuutujana jäi mudelisse vaid otsustus-

tasand: ilmnes, et kui intsidendi peab lahendama juht, siis on 36% tõenäolisem, et lahendust tajutakse organisatsiooni väärtuseid järgivana.

Järgmisena analüüsiti sama mudeli abil tegureid, mis põhjustavad kriitiliste intsidentide väärtustega vastuolulise lahenduse. Teguriteks oli Driscoll'i ja Hoffmann'i järgi pakutud: tippjuhtkonna pühendumus väärtustele (või selle puudumine), töötajate pühendumus organisatsioonile (või selle puudumine), kommunikatsioon, ressursid ja kooskõlaliste väärtuste olemasolu ja rakendamine. Kaks faktorit tõusid esile kui statistiliselt olulised, kuigi vastupidise mõjuga: tippjuhtkonna pühendumus väärtustele ning töötajate pühendumus organisatsioonile annavad 47% suurema tõenäosuse, et juhtum laheneb positiivselt. Üllatav on seejuures, et töötajate pühendumus/pühendumatus organisatsioonile seletas võrdselt nii positiivseid kui negatiivseid lahendusi, kuid negatiivsete lahenduste eripäraks oli, et enamasti leidis juhtumile ka mõni muu seletav tegur: puudulik kommunikatsioon, ressursside vale paigutus või vastuolulised väärtused. Taaskord mõjutas juhi otsustustasand juhtumeid positiivses suunas.

Analüüsi põhjal tegid autorid järgmised järeldused:

1. Kriitiliste situatsioonide lahendamise edukus organisatsiooni väärtuste seisukohalt ei sõltu juhtumi tüübist, vaid muudest teguritest.
2. Väärtuspõhine juhtimine on eelkõige seostatav juhtide endiga, mis omakorda kinnitab selleteemalises kirjanduses levinud seisukohta, et organisatsiooni väärtuseid tajuvad töötajad eelkõige juhi enda väärtuste ja käitumise kaudu. Oluline tegur väärtuspõhise juhtimise juures on ka töötajate pühendumus organisatsioonile.
3. Töötajate pühendumist organisatsioonile ja selle väärtustele sealhulgas takistavad juhtimissüsteemid, mis ei ole väärtustega kooskõlas – nt töötaja tulemuslikkuse hindamine (sh tasustamine) väärtustest erinevate kriteeriumite alusel, protseduurid, mis ei võimalda kriitilises

situatsioonis väärtustele vastavalt käituda, või puudulik kommunikatsioon.

4. Mitmel juhul polnud kirjeldatud kriitilisel situatsioonil organisatsiooni väärtustega kooskõlaline lahendus üldse võimalik, kuna juhtumis ilmnes organisatsiooni väärtuste vastuolulisus. Seetõttu on edukaks väärtuspõhiseks juhtimiseks vaja mitte ainult väärtusi toetavaid juhtimissüsteeme, vaid ka hästi läbi mõeldud kooskõlalisi väärtuseid endid.

Antud töö põhjal järeldavad autorid, et organisatsiooni väärtustega kooskõlalised lahendused kriitilistele intsidentidele on tõenäolisemad siis, kui intsidendi lahendamisest võtab osa juht. Seega leidis kinnitust, et töötajate jaoks väljenduvad organisatsiooni väärtused eelkõige juhi käitumises.

## **Example of a critical incident and its categorisation**

### **Description:**

The incident took place in a small private company where during an occasional financial audit the accountant of the company was discovered to have “borrowed” money from the company’s cash box for personal needs.

Informed of the situation, the management was extremely worried about how to handle the situation. It appeared that the accountant was indeed having an exceptionally hard time in her life and, in fact, it was not the first time for her to borrow from the company without telling anyone. There was no reason to believe she had not paid it back afterwards. However, since one of the company’s values was “honesty”, this kind of behaviour was found to be unacceptable and the accountant (a highly regarded professional, by the way) was sacked. The biggest motive for the management to reach that solution was to send a clear message to the rest of the employees that “honesty” is important and not to be devalued, even though the accountant was professionally competent and she might have had a good reason to look for assistance.

### **Categorisation:**

- Type of a Critical Incident: Human Resource
- Outcome in the light of Values: Positive
- Reasons behind the solution: Commitment from the top, Communication
- Company Size: Small
- Sector: Private
- Level of Judgement in the Critical Incident: Manager

### Testing control variables to predict positive outcomes for critical incidents

| Probit estimates                   | Number of obs = |                 | 95          |              |                |   |                |   |                |
|------------------------------------|-----------------|-----------------|-------------|--------------|----------------|---|----------------|---|----------------|
|                                    | Wald chi2(7) =  |                 | 16.43       |              |                |   |                |   |                |
|                                    | Prob > chi2 =   |                 | 0.0215      |              |                |   |                |   |                |
|                                    | Pseudo R2 =     |                 | 0.1451      |              |                |   |                |   |                |
| Log pseudo-likelihood = -56.288582 |                 |                 |             |              |                |   |                |   |                |
|                                    |                 |                 |             |              |                |   |                |   |                |
| Robust                             |                 |                 |             |              |                |   |                |   |                |
|                                    |                 |                 |             |              |                |   |                |   |                |
| Positive                           | dF/dx           | Std. Err.       | z           | P>z          | x-bar          | [ | 95%            | ] | C.I.           |
|                                    |                 |                 |             |              |                |   |                |   |                |
| <b>q*</b>                          | .0931262        | .1868982        | 0.50        | 0.620        | .294737        | - | .273188        |   | .45944         |
| <b>hr*</b>                         | -.2523415       | .1528284        | -1.58       | 0.115        | .326316        | - | .55188         |   | .047197        |
| <b>c*</b>                          | -.1765016       | .1729342        | -0.98       | 0.326        | .2             | - | .515446        |   | .162443        |
| <b>public*</b>                     | -.041196        | .1493966        | -0.28       | 0.783        | .336842        | - | .334008        |   | .251616        |
| <b>small*</b>                      | .0106595        | .1519804        | 0.07        | 0.944        | .357895        | - | .287217        |   | .308536        |
| <b>medium*</b>                     | -.1324422       | .1525149        | -0.85       | 0.397        | .157895        | - | .431366        |   | .166481        |
| <b>manager*</b>                    | <b>.3779435</b> | <b>.1042549</b> | <b>3.34</b> | <b>0.001</b> | <b>.473684</b> |   | <b>.173608</b> |   | <b>.582279</b> |

Note: q\* – quality-related incidents, hr\* – human resources related incidents, c\* – co-operation-related incidents, public\* – public-sector organisation, small\* – small organisations, medium\* – medium-sized organisation, manager\* – decision-making at managerial level.

## Testing control variables to predict negative outcomes for critical incidents

|                                    |                  |                 |              |              |                                  |
|------------------------------------|------------------|-----------------|--------------|--------------|----------------------------------|
| Probit estimates                   |                  | Number of obs = |              | 95           |                                  |
|                                    |                  | Wald chi2(8) =  |              | 29.62        |                                  |
|                                    |                  | Prob > chi2 =   |              | 0.0002       |                                  |
| Log pseudo-likelihood = -47.650095 |                  | Pseudo R2 =     |              | 0.2763       |                                  |
| Robust                             |                  |                 |              |              |                                  |
| negative                           | dF/dx            | Std. Err.       | z            | P> z         | x-bar [ 95% C.I. ]               |
| -----                              |                  |                 |              |              |                                  |
| CFTop*                             | -.3520798        | .1895788        | -1.70        | 0.090        | .315789 -.723647 .019488         |
| <b>OrgOwn*</b>                     | <b>-.5077545</b> | <b>.1551327</b> | <b>-2.74</b> | <b>0.006</b> | <b>.378947 -.811809 -.2037</b>   |
| Res*                               | -.0729049        | .1460159        | -0.50        | 0.618        | .357895 -.359091 .213281         |
| ConSt*                             | .3891301         | .1717478        | 1.60         | 0.109        | .115789 .052511 .72575           |
| public*                            | .106024          | .1495719        | 0.70         | 0.482        | .336842 -.187132 .399179         |
| small*                             | -.0349929        | .1629429        | -0.21        | 0.830        | .357895 -.354355 .284369         |
| medium*                            | .2222403         | .1561854        | 1.32         | 0.187        | .157895 -.083877 .528358         |
| <b>manager*</b>                    | <b>-.5247098</b> | <b>.1527666</b> | <b>-2.89</b> | <b>0.004</b> | <b>.473684 -.824127 -.225293</b> |

Note: CFTop\* – Commitment from the Top, OrgOwn\* – Organisational Ownership, Res\* – Resources, ConSt\* – Consistent Standards and Enforcement, public\* – public-sector organisation, small\* – small organisations, medium\* – medium-sized organisation, manager\* – decision-making at managerial level.