

Case Studies in Crisis Communication



LESSONS LEARNED ABOUT PROTECTING AMERICA'S FOOD SUPPLY

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Foreword

This monograph is funded by North Dakota State University's Food Safety Risk Assessment Grant with the United States Department of Agriculture's Cooperative State Research, Education, and Extension Service. The work was further guided by North Dakota State University's Great Plains Institute for Food Safety <<http://www.ndsu.nodak.edu/foodsafety/>> and the North Dakota State University Risk and Crisis Communication Project <<http://risk-crisis.ndsu.nodak.edu/index.html>>.

As with any endeavor, there are people who should be recognized for their contribution to the finished product. In order of involvement, this project would not have been possible without the support of the Great Plains Institute for Food Safety (GPIFS). Patricia Jensen, former Vice President of Agriculture, Food Systems and Natural Resources at North Dakota State University and co-founder of the GPIFS, and Douglas Freeman, director of the GPIFS, were instrumental in securing support for this project. We also want to acknowledge Catherine Logue, principal investigator for the Food Safety Risk Assessment grant, for her guidance on this project. The associated staff of the Risk and Crisis Communication Project at North Dakota State University willingly contributed to numerous discussions as this project took shape; especially Steven J. Venette, who provided helpful leadership for the graduate students who authored manuscripts for inclusion. The authors listed in this monograph were diligent in their efforts to produce high quality manuscripts. We were pleased when the Public Relations Division of the Central States Communication Association awarded this group the Top Panel Award in 2005 and McIntyre was one of three top paper award recipients. Thomas J. Riley, Dean of the NDSU College of Arts, Humanities, and Social Sciences and Director of the Institute for Regional Studies approved this monograph's publication. Finally, we wish to thank Chandice Johnson for his editorial assistance as we sought a common voice for the collected works of ten authors; and Ross Collins, acquisition editor for the Institute, for his patience and creativity in designing the publication. Our hope is that this project will be useful to scholars and practitioners in their research and teaching about risk and crisis communication.

T.L.S.
R.S.L.

Chapter
1
Introduction

OVER THE PAST DECADE, crisis and risk increasingly have become a common part of most conversations and daily life. While much of the public's attention has focused on security issues and the eradication of terrorism following the attacks on September 11, 2001, the food supply also has drawn considerable attention due to its impact on consumers, producers, and policymakers at all levels. One area of this interest focuses on accidental food contamination; that is, the tainting of food occurring naturally within the food system. The other focus centers on deliberate actions that are taken by individuals, groups, or companies to modify or contaminate the food supply.

Regardless of whether contamination is intentional or accidental, food safety is a primary concern. The Centers for Disease Control and Prevention

estimate that 76 million cases of foodborne illness occur annually in the United States alone. Of the 76 million cases, approximately 325,000 are so severe that the victim must be hospitalized; and sadly, 5,000 people die due to foodborne illnesses every year (Centers for Disease Control and Prevention, 2005). Combining these statistics with the threat of intentional terrorist contamination reveals the compelling need for understanding effective crisis communication strategies in the food safety context. Since food safety is a major concern for everyone, when facing a crisis outbreak caused by accident or intentional actions,

the response strategies undertaken by managers who are dealing with these crises have the potential to inform and instruct others who find themselves in similar crisis situations. This collection of essays identifies best practices in crisis and risk communication with a focus on public relations, communication ethics, the urgency of dissemination, and the need for efficiency. In addition to identifying the best practices, this collection enables various publics who may be in crises to review and consider the responses and lessons learned by those with first-hand experience in dealing with similar situations.

Organizational Learning

To better understand the case studies identified in this collection, a review of theories related to crisis and risk communication is useful. Because we approach these cases looking for the strategies and practices used by individuals to deal with and communicate about crises, the concept of organizational learning is central to our understanding. Organizational learning is drawn from general systems theory. That is, just as all variables influence each other in a system, when a crisis occurs in an organization, every aspect of the entity is affected.

Seeger, Sellnow, and Ulmer (2003) describe organizational learning as “both the process whereby members acquire new knowledge, responses, or skills and the systemwide modification of culture, procedures, and practices” (p. 36). As individuals within organizations observe the pre-crisis, crisis, and post-crisis events as they unfold; they evaluate the viability of particular strategies, determining those to be repeated and those to avoid in future similar situations. Adaptation is central to organization learning; in that, as an organization or group experiences a crisis, new understanding is gained requiring accommodation and the replacement of concepts previously held by those affected by the crisis.

Organizational learning is particularly important in post-crisis contexts because managers want to know what happened, why the crisis occurred,

Adaptation is central to organization learning; in that, as an organization or group experiences a crisis, new understanding is gained requiring accommodation and the replacement of concepts previously held by those affected by the crisis.

and what strategies will preempt similar crises in the future. Organizations that have a common perspective about the importance of adapting to changes brought on by a crisis, the willingness to plan for future crises, and the vision to view moving through a crisis as a chance for the creation of a renewed sense of purpose can be characterized as learning organizations (Senge, 1990).

Huber (1996) provides an explanation of the stages organizations experience as they establish their identity through the learning process. These stages include:

- Acquisition of knowledge.
- Distribution of information among various sources.
- Interpretation of information when commonly understood interpretations are available; and
- Storing of knowledge for future use, in organizational memory. (pp.124-127).

Seeger et al. (2003) extended Huber's analysis, suggesting that learning involves higher level interpretative and institutionalizing processes (p. 40).

This is where mindfulness enters the organization. As members of the organization become more aware of effective crisis management strategies, they become conscious of how their statements and actions influence their perceived success or weakness in managing a crisis. Organizations that do not learn from their mistakes will fail, while those who become mindful of their mistakes and seek a renewed perspective will likely endure.

Since food safety is a major concern for everyone, when facing a crisis outbreak caused by accident or intentional actions, the response strategies undertaken by managers who are dealing with these crises have the potential to inform and instruct others who find themselves in similar crisis situations.

The Case Study Approach

One of the best ways to learn about various communication strategies for responding to a crisis is to study of how a number of different entities dealt with the unique aspects of their crisis situations. This commonly is called the case study approach to research. Case studies have been widely used when examining crisis situations due to their descriptive and interpretive functions. The benefit of this collection of cases is the opportunity for readers to compare and cross-apply the best practices to different crisis situations.

For our purposes, we propose that the case study method is both an approach to research and a choice of what to study (Patton, 2002). As researchers, we used a common framework for analyzing the data available from public communication and the media in the construction of the case studies, thus acknowledging the methodological emphasis. Concurrently, the essays we chose to include represent individual cases whereby lessons were learned and best practices isolated and studied. We approached the case studies holistically and individually. Within the broader context of food safety, the crises were studied as organizational responses to accidental or intentional contamination. As an individual crisis, each study included context-sensitive information reflective of how the organization responded.

To provide clarity, each case study was written to include common elements that would provide comparable information for the reader to follow. These included:

- General introduction, with a research question specific to each case,
- A chronological timeline and brief scenario for how the crisis

- developed using pre-crisis, crisis, and post-crisis parameters,
- The database comprised of printed material drawn from media available to the public,
- Common method for presenting data and analysis that involved describing, interpreting, and evaluating the practices used in each case,
- Conclusions to be drawn from the failures, successes, and lessons learned, and

In this case, our goal is to provide consumers, producers, and managers of the food supply with a collection of case studies where best practices and lessons learned can be identified, providing readers with insight into ways to successfully manage crisis and risk in the future.

- Implications for best practices.
From a research perspective, this format provided for consistency across the different studies. For example, there were categories for analysis, a timeline of the crisis, and lessons learned. The information for the case studies in this collection was drawn from public media, providing the reader with comparable data to analyze.

Six Cases of Crisis Communication in

Food Safety

Denzin and Lincoln (2000) suggest that, “perhaps the most unique aspect of case study is the selection of cases to study” (p. 446). In this case, our goal is to provide consumers, producers, and managers of the food supply with a collection of case studies where best practices and lessons learned can be identified, providing readers with insight into ways to successfully manage crisis and risk in the future. Each case study is unique in its area of contamination, the agent, the product, and how the organization or community responded. The first four cases describe accidental contamination (three involving company responses, one examining an interagency response), while the last two cases illustrate intentional modification with different intended results (one company-driven modification to increase food production, the other prompted by a cult seeking to influence local politics).

“Social Responsibility: Lessons Learned from Schwan’s Salmonella Crisis,” by J.J. McIntyre, examines the role of social responsibility during Schwan’s salmonella outbreak. The study used newswire and major newspaper articles to construct a case study identification to establish both the crisis and post crisis description of events surrounding the nation’s largest single vehicle outbreak of salmonella enteritidis. An analysis of Schwan’s crisis displays a lack of industry vigilance, probably responsible for the outbreak. Schwan’s maintained legitimacy through the crisis and demonstrated a high degree of social responsibility in its use of corrective action that mimicked Johnson & Johnson’s handling of the Tylenol crisis.

Lisa Sjoberg’s chapter, “Chi-Chi’s Crisis: Lessons Learned Through the Use of Organizational Apologia,” examines how external agents affect organizational apologia. Approximately one hundred newspaper articles were gathered to generate a case study of the Chi-Chi’s organization and its Hepatitis A outbreak. After rhetorically analyzing the case study, it is evident that Chi-Chi’s spokespeople were effective in their use of apologia because they used a justificatory approach to manage the external agents that affected the crisis. While their apologia was effective overall, a more upfront approach with various constituents would have improved Chi-Chi’s response to this social legitimacy crisis.

“Jack in the Box: Lessons Learned by Accepting Responsibility,” by Robert

S. Littlefield, explores the pre-crisis, crisis, and post-crisis phases of the 1993 E. coli outbreak at the Jack in the Box restaurants in the Seattle, Washington, and surrounding areas. Theoretical insight drawn from organizational learning theory and the development of a Crisis Management Plan suggest that corporate managers could have improved communication with various stakeholders and acted more systematically to frame, oversee, and track their responses to the crisis.

The chapter, “Crisis Plans and Interagency Coordination: Lessons Learned from Tainted Strawberries in the School Lunch Program,” by Julie M. Novak, highlights the importance of pre-crisis planning with appropriate stakeholders through an exploration of a 1977 Hepatitis A outbreak in the National School Lunch Program. When multiple agencies at many levels are responsible for protecting the health and well-being of school-aged children, prior planning facilitates efficient and effective coordination. Review of this crisis provides for lessons learned and optimal development and updating of preparedness and crisis planning.

Response to the diffusion of genetically modified wheat is the subject of Agnes N. Lyonga’s paper, “Monsanto’s Genetically Engineered Wheat Crisis: Lessons Learned from Faulty Diffusion Strategies.” On 30 July 2002, Monsanto pulled back its stated timeline for bringing the first genetically engineered wheat to market by 2005 and announced on 10 May 2004, that it was dropping plans to commercialize the crop after spending seven years and hundreds of millions of dollars researching and developing it. The data used for this study were online newspaper articles, Monsanto annual reports, and other on-line reports on food biotechnology research. After a long struggle to impose GE wheat onto its stockholders, Monsanto finally realized that there was no need/problem that necessitated its innovation, especially with the increased public awareness, global fear, and outrage concerning genetically modified organisms (GMOs).

“Biological Terrorism and the Local Community: Communication Needs and Response,” by Patric R. Spence and Kenneth A. Lachlan is an exploration of intentional food contamination, and focuses primarily on the Bahgwan Shree Rajneesh cult in Wasco County, Oregon. In 1981, cult members attempted to influence the outcome of a local election by contaminating salad bars in local restaurants. They conclude by suggesting that contamination of the food chain may occur at a variety of points in the system, with the result compromising the faith of the public in the security of the food supply.

The afterword, “From Food to Fork: Communication and Best Practices in Food Safety,” by Matthew W. Seeger, offers an explanation of the factors causing an increased awareness of food contamination outbreaks, and a call for organizational learning and mindfulness as more occurrences of accidental and intentional food contamination appear in the future.

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When multiple agencies at many levels are responsible for protecting the health and well-being of school-aged children, prior planning facilitates efficient and effective coordination.

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Chapter

2

**Social Responsibility:
Lessons Learned from
Schwan's Salmonella
Crisis**

**J. J. McIntyre
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Small businesses are a vital part of our nation's economy; however, a few entrepreneurs are not content to remain small. These ambitious spirits possess a drive enabling them to grow their local businesses into empires. These local giants' unique foundations set them apart from the corporations explored in this book.

Privately-owned companies operate in a cohesive manner, often relying on close family ties and local stakeholder vestment. The large base of support, coupled with the benefits of a company status,¹ creates a unique social and communication perspective. When a crisis occurs, multiple groups are affected, and this study will examine how a company copes with the adversity of a crisis situation.

Schwan's, a family-owned and operated company based in Marshall, Minnesota, is a major player in the local, national, and global food industry. In 1994, Schwan's was faced with the largest common vehicle salmonella outbreak in history (Hennessy et al., 1996). This study will examine how Schwan's dealt with the crisis and discuss the lessons that can be used to construct best practices for company practitioners.

Research Questions

How did Schwan's maintain legitimacy through the salmonella outbreak and act in a socially responsible manner? What specific actions did Schwan's take during the outbreak that were not only seen as legitimate but considered socially responsible and why?

Crisis Timeline

Schwan's has hit a few bumps on the road to success. The company has met and overcome at least five potentially devastating incidents: a flood in the 1950s, a fire in 1970s, razor blades in pizza packaging in the 80s, and the death of company owner Marvin Schwan in 1993, a year before the salmonella outbreak.² This study will concentrate on the most recent and most severe of the exigent situations, the salmonella enteritidis outbreak of 1994, when the company's cumulative crisis experience was put to the test.

| | |
|-----------------|---|
| 7 October 1994 | Schwan's is notified of a possible connection between their ice cream products and a salmonella outbreak. |
| | Marshall plant is closed and a recall is issued. |
| 12 October 1994 | Schwan's ice cream is positively linked to salmonella. |
| 29 October 1994 | Schwan's announced safety improvements that will be implemented to prevent future contamination. |
| 14 October 1994 | Initiated free hot line and medical testing. |
| 7 November 1994 | Marshall plant reopened. |
| 3 February 1995 | Schwan's reached a tentative agreement with the class-action lawsuit. |
| 30 August 1995 | Settlement approved by the court. |
| 18 October 1994 | Schwan's cleared of all wrongdoing. |

Theoretical Underpinnings

To gain deeper insight into what happened to Schwan's during its national crisis it is beneficial to examine some of the existing literature on corporate

¹ Companies do not have to publicly disclose financial reports, nor do they need to worry about stockholders or stock prices during a crisis situation.

² Relatively little is known publicly about the crises mentioned, but a future exploration into the common threads of crisis management is certainly warranted.

responsibility. Schwan's is a privately-owned company and not a corporation. Nevertheless, its large size, multinational status, and diversity of products, services, and stakeholders justifies the use of existing corporate literature on social responsibility to describe, interpret, and evaluate its social actions.

The term corporate citizen is an apt description of a corporation's role in society. Social expectations, combined with legal rights and duties, illustrate the complex role of a country's citizens. Corporations and companies are organizations that can be viewed as citizens of the countries where they conduct business (Tombs & Smith, 1995). The citizen paradigm provides a set of guidelines to use when choosing and evaluating appropriate behavior. For example, a company existing as a discrete entity is bound to act by the laws of the land or face a penalty fitting the crime. At the same time, laws give companies the legal rights and protection they need to operate—the same as an individual citizen.

A corporation has legitimacy if it is still operating, but socially responsible behavior must at least maintain legitimacy in order to be classified as socially responsible. The two terms are intimately intertwined and dependent on each other.

In addition to legal rights and obligations, a company is faced with establishing and maintaining social legitimacy with its stakeholders. Organizational legitimacy is the public-given right of an organization to exist. Legitimacy is similar to a popularity contest where the loser is told not to compete anymore. Metzler (2001) argues, "Legitimacy is based on the actions of an organization and responsible communication about them [the actions]" (p. 321). The dual responsibilities of maintaining legitimacy is a never-ending job for the public relations department and the management of an organization.

Tombs and Smith (1995) contend that corporations acting socially responsible must exceed the platform of legitimacy. Corporate responsibility and legitimacy are both judged on the merits of action and communication as described above; however, social responsibility "requires classification within a framework of acceptable corporate behavior" (p.136). A corporation has legitimacy if it is still operating, but socially responsible behavior must at least maintain legitimacy in order to be classified as socially responsible. The two terms are intimately intertwined and dependent on each other.

There are three types of corporate social responsibility which are viewed as increasingly responsible (Tombs and Smith, 1995): liberal, paternalist, and democratic.

- Liberal forms are concerned with following the basic rules of society, but assert the sole responsibility of the corporation is to follow the owners' wishes—which is usually to make as much money as possible within societal rules.
- Paternalist forms recognize the inclusion of stakeholders and the existence of a social contract between the corporation and society.
- Paternalist organizations will shift their practices to respond to current social callings; however, the interaction between the organization and its stakeholders remains circumscribed because the corporation determines the stakeholder's legitimacy to the process.
- Democratic forms of corporate social responsibility require transcendence from compartmentalized knowledge. This form also recognizes "the legitimacy of a plurality of views, voices and rationalities exists within the process" (p. 140). In this view, stakeholder participation is exponentially increased and the

responsibilities and direction of the organization are shared.

Each form of corporate social responsibility briefly described here does make necessary changes to maintain legitimacy. The differences between the forms emerge from their efforts to include multiple stakeholders in varied processes.

Method

Database

Major paper and newswire articles retrieved from the *Lexis-Nexis* Academic Database yielded 52 articles that were used to examine the events of the outbreak. The articles range in date from 7 October 1994 to 16 May 1996. Official responses from both the Schwan's company and participating government agencies were also taken from the articles. News articles were used in this study to demonstrate what the general public knew about the crisis.

Approach

Articles in the database were used to conduct a case study identification to construct the crisis- and post-crisis descriptions of the events surrounding the salmonella enteritidis outbreak. Quotations and other information used in this study were taken from news sources that were either the first to report the information or presented a more comprehensive account of the event. Accuracy of the statements made in early reports was checked by using later articles that supported the claim. General information about the Schwan's company was obtained from an academic search in Infotrac, *Lexis-Nexis*, the Internet (Google), and the Schwan's Company website.

Analysis

Pre-crisis

The Schwan's ice cream business was born out of necessity. In the early 1950's, the government put a price freeze on retail milk prices, but farmer's prices were left open to market demand. Caught between shrinking profit margins, the family business almost went bankrupt. Marvin Schwan, using his knowledge of ice cream production, had an idea to make ends meet. He bought an old 1946 Dodge van, loaded it up with 14 gallons of ice cream packed in dry ice, and went door to door to the area's farm families. When Marvin returned home that evening the van was empty and Schwan's home delivery was born (Schafer, 1995).

Marvin continued to demonstrate ingenuity and creativity in his business practices. For example, the cheese surplus in the 1980's resulted in the Department of Agriculture giving away huge stockpiles of cheese to public schools. Marvin saw an opportunity and took advantage of the situation by offering schools discounts on frozen pizza in exchange for the school's cheese allotments. The beneficial relationships developed into hundreds of school contracts. Eventually, the Schwan's company earned over 70% of the market share in the school market (Fritz, 1989). Frozen pizza and ice cream remain a cornerstone of the company; still, Schwan's continues to persist in a tireless pursuit of expansion.

Schwan's has continued to diversify and expand its business both in the United States and abroad. There are now three divisions in the Schwan Food Company and three additional subsidiary businesses that focus on alternate

fuel injection systems, automobile insurance, and inbound/outbound customer phone service. The Schwan's company has also exploded into the global market, operating in over 50 countries, and selling many easily recognized food brands including: Tony's, Red Baron, Chicago Town, Freschetta, Pagoda, and Larry's (The Schwan Food Company, 2003b).

Indications of a problem began to surface when 67 confirmed cases of salmonella enteritidis infection were reported to the Minnesota Department of Health and an additional 14 cases were reported in the neighboring state of South Dakota (Slovut, 1994b).

Crisis

Schwan's resolve was put to the test on a Friday morning in October 1994. The Minnesota Department of Health notified Schwan's of a correlation found between a recent increase of salmonella enteritidis infections and the company's ice cream. The number of infections was much higher than normal levels and health officials indicated the possibility of an outbreak emerging.

Salmonella is a bacterium that flourishes in moist foods such as poultry and dairy products. The cause of the salmonella infections was still not positively identified, but a strong link to the ice cream did exist: "Most of those infected have one thing in common: They ate ice cream manufactured at the Schwan's plant in late August or early September" (Slovut, 1994b). Some of those already infected by the bacteria were hospitalized with flu-like symptoms, but no deaths were reported.

Produced in Marshall, Minnesota, Schwan's ice cream is typically distributed directly to consumers by delivery drivers in the 48 contiguous states. The ice cream is not generally sold in grocery stores, but is carried by at least two Minnesota supermarket chains (Slovut, 1994b). After speaking with officials from the Minnesota Department of Health, Schwan's "agreed to stop manufacturing, distributing and selling ice cream from the plant until the source of the contamination has been found" (Slovut, 1994b).

The Minnesota Health Department acted immediately by issuing a statement to the public not to eat any Schwan's ice cream products. The health departments of other states and the U.S. Center for Disease control and Prevention (CDC) were notified of the situation. A hotline was established to answer consumer's health questions and arrange for testing people who had eaten Schwan's ice cream and displayed symptoms of salmonella. Later the same afternoon, officials from the state Health Department, U.S. Department of Agriculture (USDA), and U.S. Food and Drug Administration (FDA) began investigating the Marshall plant for a contamination source (Slovut, 1994b).

The next day, Schwan's held a press conference and issued a recall of all its ice cream products. Dave Jennings, spokesperson for Schwan's, was paraphrased as saying "his company had not been ordered by any health agency to recall its product but that production had stopped and all the company's ice cream would be held back" (Blackwood, 1994).

During the following week, Schwan's started to feel the gravity of the situation. Reports of salmonella poisoning increased dramatically across the continental United States and by Tuesday infections were linked to hundreds of reports in 14 states (Kuebelbeck, 1994a). Minnesota state epidemiologist, Michael Osterholm, stated the outbreak was "probably the single biggest food-

Produced in Marshall, Minnesota, Schwan's ice cream is typically distributed directly to consumers by delivery drivers in the 48 contiguous states.

borne outbreak that I've been involved with in 20 years" (Kennedy, 1994d). Class action lawsuits were immediately filed against Schwan's, "alleging that their clients became ill because Schwan's failed to prevent or discover the salmonella" (Slovut, 1994b). By the end of the week, reports of possible salmonella cases again skyrocketed. The Associated Press reported, "Ice cream made in Minnesota is now blamed for thousands of suspected cases of salmonella in at least 35 states" (Kuebelbeck, 1994b). Jennings responded to the blossoming crisis by saying, "Will it hurt our reputation? Of course it will" (Kennedy, 1994d).

One week after Schwan's was informed of the crisis situation, the Minnesota Department of Health, believing enough information about the outbreak has been collected, closed its hotline (Slovut, 1994c). The same day, Schwan's established a new hotline for customers to receive information on a free salmonella test by their own physicians (Schwan's to pay for customer tests," 1994). Schwan's paid the medical bills for all concerned consumers.

Meanwhile, Schwan's made an attempt to keep customers in ice cream. The company temporarily moved its ice cream production to the Wells Dairy facility in LeMars, Iowa. Jennings explained the company's decision to continue production, "We're trying to produce some flavors to meet some of the demand" (Kennedy, 1994d). Although not all flavors were produced and volume did not meet normal levels, production continued at the LeMars plant until the Marshall plant reopened. While health officials continued the plant investigation, an estimated 130 employees of the Marshall plant were laid off ("Schwan's ice cream tested for salmonella," 1994, Kennedy, 1994b).

The contamination investigation of the Marshall plant continued to develop slowly. David Kessler, FDA Commissioner, told reporters, "It is enormously difficult to do this kind of scientific detective work" (Schwartz, 1994). Jackie Refiner, a spokesperson for the Minnesota Agriculture Department, said, "We're looking at everything from the ingredients to the mixes to the transportation system to the plant. We're trying to determine in which of those areas the salmonella might be growing and how it got there" (Kuebelbeck, 1994b).

Almost two weeks after the investigation began, a positive link between Schwan's ice cream and the salmonella outbreak was found in an unopened container of ice cream from the plant in Marshall (Slovut, 1994a). The next day, the Schwan's plant outbreak was "traced to a shipment of raw eggs carried in a tanker later used to transport pasteurized ice cream products" ("Schwan's takes salmonella safeguards," 1994; "Truck transporting eggs could be source of salmonella outbreak," 1994). While salmonella was not found in any of the trucks, it was established as the most likely cause of the outbreak (Sandok, 1994).

The following day Schwan's publicly responded to the health officials' investigative findings. Schwan's announced the "immediate implementation of a number of voluntary measures that should provide every possible safeguard to ensure the safety of those ingredients that are delivered into our plant" (Slovut, 1994d). The two-pronged approach included using a dedicated fleet of tankers to carry ingredients and re-pasteurizing the ingredients at the plant.

One month after the crisis began, Schwan's was allowed to reopen the Marshall plant (Sandok, 1994). The company's attention became focused on the legal ramifications of the crisis. Schwan's used its close customer contacts to settle much of the matter out of court. Customers were asked to sign a statement releasing the company from further liability in exchange for cash or gift certificates. The payments averaged about \$160 to each of the 6,000 customers who signed the agreement. The company's insurance carrier was also

involved in the process. Liberty Mutual's adjusters called customers, offering to settle for as little as \$25.00 a person (Kennedy, 1994b). When class-action lawsuit lawyers publicly brought these actions into question, Jennings stated, "The settlement strategy is designed to build and protect customer loyalty. If it also serves to weaken the class-action effort, so be it" (Kennedy, 1994b).

Post-crisis

Almost four months later, the tentative settlement agreement between Schwan's and its customers involved in the class-action lawsuit was legally approved.³ Individual compensation ranged from \$25.00 to \$75,000.00 per person, depending on the severity of his or her sickness ("Judge approves settlement over Schwan's salmonella outbreak," 1995). On 18 October 1995, just over a year after the crisis surfaced, Schwan's was cleared of wrongdoing by state inspectors. Schwan's did not pasteurize its products at the plant in Marshall before the crisis, but they were not required by law to do so. Despite the company's name being cleared with no fine imposed, Schwan's agreed to pay the state \$60,272 to cover the expenses incurred from the outbreak (Kennedy, 1995b).

On 18 October 1995, just over a year after the crisis surfaced, Schwan's was cleared of wrongdoing by state inspectors.

Schwan's is stronger than ever and has expanded its enterprises even further. Currently, "the Schwan Food Company is America's leading branded frozen-food maker" (The Schwan Food Company, 2003b). The Schwan's website attributes the success of the company to expansion: "Acquisitions and start-ups play key roles in a company dedicated to achieving its vision for growth" (The Schwan Food Company, 2003a). Since the outbreak in 1994, the number of employees has quadrupled and sales have doubled. In 2003, the still privately-owned Schwan's company reported combined sales reaching \$4 billion while employing 24,000 people worldwide (The Schwan Food Company, 2004).

Conclusions

Where Schwan's Failed

Schwan's pasteurization practices, while legal, were shown to be inadequate and the company's lack of industry vigilance might have been responsible for the onset of the crisis. The shortcomings of the pasteurization process were responsible for the salmonella bacterium surviving in Schwan's ice cream. While production at Schwan's met industry regulations on the pasteurization of ingredients, most of the industry used a different technique that provided better safety for consumers. Reporters noted that most ice cream in the United States is pasteurized immediately before processing. However, in the Schwan's case, it was pasteurized then shipped as a mix to another plant without being re-pasteurized. The differences between the two processes proved costly to Schwan's reputation as a provider of quality foods.

Schwan's worked hard to keep its customers out of the courtroom, but at least two class action lawsuits surfaced⁴ in the aftermath of the crisis. Before the class action lawsuits began to surface, both Schwan's and its insurance carrier tried to settle out of court with many consumers. The actions can be viewed as both a success and a failure. Schwan's did succeed in keeping many potential litigants out of class action lawsuits, but its actions may have hurt its public image.

³ Kennedy mentioned a class action in Illinois, but no more information was found on the case.

⁴ The Minnesota lawsuit was settled without a trial and another lawsuit, originating in Illinois, was mentioned in Kennedy (1995a), but the case dropped out of the media.)

Stakeholders, due to their diversity, may differ in their perceptions of Schwan's actions. Customers and other stakeholder groups who were watching the process unfold could have perceived news about the settlements as underhanded. Alternatively, stakeholders may have perceived the strategy positively. The actions taken could have also displayed the company's good intentions toward earning and retaining customer loyalty. While figures released about the lawsuit do not include lawyer fees or the plaintiff's time, compared to consumers who signed a settlement directly, Schwan's paid a bit more to class action lawsuit plaintiffs.

Schwan's messages were marked by specific actions that went beyond what was asked for or demanded by authorities. The actions not only served to protect the company's legitimacy, but went a step further to display social responsibility.

Where Schwan's Succeeded

Stakeholders base their judgment of an organization's legitimacy both the actions it takes and its communication of these actions to stakeholders (Metzler, 2001). Schwan's excelled in both areas simultaneously. First, Schwan's displayed a continuous

concern for its customers through socially responsible actions. Second, the company produced focused messages from a solitary spokesperson that created a unified and consistent flow of pertinent information to stakeholders. The areas could be separated into individual functions of crisis response; however, Schwan's successfully tied the two areas together in a nearly seamless fashion by the timely announcement of implemented corrective actions.

Action and communication

Schwan's messages were marked by specific actions that went beyond what was asked for or demanded by authorities. The actions not only served to protect the company's legitimacy, but went a step further to display social responsibility. Recognizing different viewpoints within society, Schwan's response to the crisis draws largely from the democratic form of corporate social responsibility, which is the most responsible behavior on the continuum (Tombs & Smith, 1995). The following list exhibits Schwan's socially responsible actions during and after the crisis and what stakeholders were told about Schwan's actions via the media.

- Shutdown production facility, ordered an investigation of the plant, and immediately ordered recall.
- Offered customers compensation for possible tainted products.
- Initiated a hot line for consumer questions, concerns, and testing information.
- Paid for medical services and diagnostic testing conducted by the customer's doctor.
- Offered compensation to consumers who became ill from salmonella. Settled a class action lawsuit.
- Reimbursed expenses the state incurred during the crisis.

Schwan's was in continuous contact with the media, announcing the actions it was taking to help correct problems as or before they arose. When the crisis situation changed, Schwan's was prepared to respond with well-thought-out comments and a specific action that appeared to be in the best interest of consumers. Schwan's immediate implementation of voluntary measures throughout the crisis displayed a steadfast responsibility to its numerous stakeholders.

Schwan's recognized the multiple viewpoints held by stakeholder groups, and the company's unique qualities were put to use in satisfying the various concerns. Initially, worried consumers could call a 24-hour hotline to find out how to get a free medical test by their own doctors. The calls were handled by Schwan's personnel who could answer and respond to individual concerns that were ultimately given a voice through the hotline (Sellnow, Ulmer, & Snider, 1998).

Customers were later contacted either by door-to-door delivery drivers or by phone calls to discuss possible compensation for their sickness or inconvenience. Consumers could choose to be compensated by gift certificates, cash payment, or a combination of both in return for signing a statement agreeing not to sue.

Individuals who did not find this practice fair could join the class action lawsuit. Schwan's would have preferred all of its customers sign the release statement; however, official statements tended to direct hostility toward the victim's lawyers and not the victims themselves. Schwan's statements also countered the plaintiff's lawyer's public complaint that Schwan's was undermining the class action lawsuit by saying, "If that means the plaintiffs' attorney doesn't make as much money off the lawsuit, that's an outcome I can live with . . . We don't feel like we need a class action to explain our obligation is to our consumers" (Kennedy, 1994c). Schwan's lawyer, Jim O'Neal, later reiterated the sentiment. O'Neal was paraphrased as saying, "Schwan's wants to mend differences with its customers instead of fighting them in court" (Kennedy, 1995b).

The compassion for affected consumers remained constant throughout the different campaigns, as did the recognition of multiple stakeholder groups. Clearly, Schwan's still felt obligated to those who did not want to settle beforehand. Failing to see the class action suit as legitimate, while at the same time recognizing the individual claims as legitimate, reinforces the claim that Schwan's was acting in a democratic form of social responsibility. It could be argued (perhaps a bit unfairly) that the actions were self-serving and legally motivated; however, the general public and previous scholarly work (Sellnow, et al., 1998) perceived the actions as sincere—even if they were mutually beneficial.

What Schwan's Learned

Schwan's handled the crisis effectively, using corrective action as the primary response strategy during the crisis (Sellnow, et al., 1998). The corrective actions were proactive and consistently above and beyond what health authorities ordered or even suggested.⁵ The socially responsible corrective actions placed retaining the company's reputation and customer base above immediate financial issues. Schwan's did not over-react nor under-react to situations as they arose. The actions taken by the company were well received, both nationally and locally. Questions concerning the company's legitimacy were almost nonexistent, reinforcing the idea that Schwan's took care of affected consumers.

Implications

Schwan's extremely private nature, coupled with its residency in a

⁵ Health authorities suggested that Schwan's should either start using a dedicated fleet of sealed tanker trucks to deliver ingredients or repasteurize every shipment of ingredients. Schwan's publicly announced it would implement both measures (Slovut, 1994f).

Schwan's extremely private nature, coupled with its residency in a small town, helped create a favorable image in the media.

small town, helped create a favorable image in the media. Unbiased outside information about the Schwan's company is hard to find. Reporters trying to uncover the inner workings of Schwan's were met by local resident's reluctance to speak out about the company. "People don't speak out of line about the company, or are afraid to talk, because everyone wants to respect [Schwan's] wishes" (Kennedy, 1994a). Instead of exposing dirt on the company, reporters printed endearing background information about Schwan's, such as this anecdote:

In the beginning, there were just chocolate and vanilla. Those two ice cream flavors were all Marvin Schwan sold to area farm families when he founded his home delivery service in 1952 with a truck he bought for \$100. He refrigerated the vehicle with dry ice and pounded out a route. It wasn't an easy ride; the truck got 22 flat tires or blowouts in that first year alone. (Kennedy, 1994a)

Similar stories are commonly found in both local and national news reports. News organizations frequently portrayed the Schwan's company as a symbol of the American Dream. The reports may have resonated with the common man, but the company shows no desire to be placed with other companies. A New York Times article commented on a wooden sign hanging in the company's lobby that says simply, "The Uncommon Company" (Feder, 1994). The charming accounts may have served to soften the news of the outbreak and even persuade people to root for the company during the crisis.

Schwan's company status seemed to be a large benefit during the crisis. The company did not have to consult a large organizational bureaucracy to make decisions and was able to react quickly to the changing situation. The effective actions did not lack in morality or responsibility and often disregarded immediate financial repercussions.

The combination of the above benefits allowed consumers to feel comfortable with the company's leadership. After the crisis, Schwan's was able to sink back into the comfortable realm of obscurity. There were no complaints from stockholders or market analysts, and the company could choose not to disclose other information. Once the public's health was not in danger, the general public could easily forget about the incident because they had nothing to gain or lose from following the company's actions.

Schwan's appears to have adopted Tylenol's corporate strategy of crisis management. A former Marvin Schwan lieutenant was paraphrased as saying, "Schwan's response to the salmonella outbreak will resemble Johnson & Johnson's textbook handling of the deadly tampering with Tylenol" (Kennedy, 1994a). Tylenol's strategy, at a basic level, included an immediate product recall, followed by the adoption of improved safety measures to smooth reintroduction. Schwan's actions followed this general format, and displayed the benefits of organizational learning. The Tylenol strategy appears to be generalizable to other business, on both the corporate and company level, and may serve as a template for other organizations facing a large-scale public crisis for the first time.

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Chapter

3

**Chi-Chi's Crisis:
Lessons Learned
Through the Use
of Organizational
Apologia**

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In 1976 the conversion of a Minneapolis sports bar to a Mexican eatery created the well-known chain of Mexican restaurants known today as Chi-Chi's. One year later, Chi-Chi's had expanded to four restaurants and by 1980 ninety-two locations speckled the United States from coast to coast (Robinson-Jacobs, 2003). Chi-Chi's has continued to expand, with an annual revenue reaching \$200 million in 2000.

Despite its trademark menus and financial success, Chi-Chi's has not been without its problems. In 1994, Chi-Chi's was sold to Family Restaurant's, Inc., which later changed its name to Prandium, under whose ownership Chi-Chi's remains. Although it had experienced financial success for many years, Chi-Chi's and other Prandium, Inc., chains, including Koo Koo Roo, declared bankruptcy on 8 October 2003. According to the *Orlando Sentinel*, the reason for this bankruptcy filing was cash flow problems the restaurant had been experiencing for quite some time ("Litigation hinges," 2003).

While Chi-Chi's comprised as much as 70% of Prandium's sales, by October 2003 Chi-Chi's claimed assets of \$50-\$100 million and reported debts of over \$100 million (Robinson-Jacobs, 2003). In February 2003, Prandium hired a financial expert to combat the financial problem, which proved to be unsuccessful.

While facing bankruptcy was a problem in and of itself, Chi-Chi's faced a greater crisis in November of 2003—a major Hepatitis A outbreak linked to one of its Pennsylvania franchises. Although it was not known initially, the source of the hepatitis was imported Mexican green onions, which had also been tied to hepatitis outbreaks earlier in the fall of 2003. The circumstances surrounding the Hepatitis A outbreak—Chi-Chi's bankruptcy—affected how the restaurant handled the crisis. This essay examines the hepatitis crisis, the tactics used in Chi-Chi's public defense or apologia, and how Chi-Chi's unique situation affected this defense.

Research Questions

Apologia is a "justificatory form of corporate communication in which an organization seeks to respond to criticism through the presentation of a compelling defense and explanation of its actions" (Hearit, 1999, p. 292). While all organizations utilize apologia during crisis situations, two major external agents affected Chi-Chi's response: its vendors and its creditors. Therefore, this essay examines how external agents affect an organization's apologia.

Crisis Timeline

Pre-crisis

| | |
|------------------------------|--|
| August and September 2003 | Hepatitis outbreaks in West Virginia, Georgia, North Carolina, and Tennessee. |
| September 2003 | Chi-Chi's receives infected shipment of green onions from Mexican farms. |
| October 2003 | Chi-Chi's files for Chapter 11 bankruptcy. |

Crisis

| | |
|------------------|---|
| 3 November 2003 | Hepatitis A outbreak at the Beaver Valley Mal location and Pennsylvania is confirmed health. Officials announce hepatitis threat. |
| 13 November 2003 | Nationwide, Chi-Chi's removes green onions from menus. |

| | |
|------------------|---|
| 21 November 2003 | Green onions are declared to be the cause of the outbreak. U.S. halts all Mexican green onions imports. |
| 22 November 2003 | U.S. shuts down four companies operating eight firms that export onions to the U.S. |
| 12 December 2003 | Ten secondary Hepatitis A cases reported. |

Post-crisis

| | |
|------------------|---|
| 15 January 2004 | Beaver Valley Mall Chi-Chi's reopens. |
| 23 February 2004 | Mediation system is approved to pay hepatitis victims. |
| 26 February 2004 | Twenty-six Chi-Chi's restaurants are closed due to under performance. |
| June 2004 | Bankruptcy court approves settlements of \$2 million for 60 victims. |

Literature Review

Apologia

Apologia has long been associated with rhetoric and public speaking; however, not until the past decade has apologia been associated with organizations. In their leading study, Ware and Linkugel (1973) define apologia generally as "a speech of self-defense" and declare that it is human nature to defend oneself when one's virtue, morality, and reputation have been questioned (p. 274). Recently, many studies have utilized this notion in examining how corporations respond to the public when their images are questioned (Hearit, 1996; Hearit, 1999; Sellnow & Seeger, 2001; Seeger & Ulmer, 2002; Hobbs, 1995; Benoit & Lindsey, 1987; Ice, 1991). According to Hearit (1995), apologia in the corporate arena is often a "response to a social legitimacy crisis" (p. 1). In so responding, the organization is able to accomplish two goals: (1) create a gap between the organization and its mistakes and (2) bridge the gap between the organization and the public's values.

Publics

Every organization has different constituents that play key roles in the organization's survival and success. In the mid-to-late Twentieth Century, organizations moved toward making products *for* the public instead of trying to sell their products *to* the public. As keeping constituents or publics pleased became increasingly important, this change had an impact on public relations, "the relationships with those who constitute an organization's publics or constituents, the ways and means used to achieve favorable relationships, and the quality or status of the relationships" (Cutlip & Center, 1982, p.4).

Grunig and Hunt (1984, pp. 139-143) identify four types of publics, or "corporate relationships," and their impact on an organization: (1) enabling publics, who regulate the corporation in terms of resources and authority; (2) functional publics, who act as the inputs (labor and money) and outputs (goods and services) of the organization's system; (3) non-native publics, who develop the values of the organization through organizational societies and memberships; and (4) diffused publics such as community members, who live near the organization and are indirectly affected by the organization.

In order for organizations to use apologia effectively to handle crises, it is imperative that these publics are considered in the development of the organization's apologetic strategies. Although many crises call for apologia on

behalf of the organization, frequently an apologetic response will not be given unless “organizational publics believe the criticism to be true and there is a concomitant effect on an organization’s bottom-line” (Hearit, 1999). Depending on which of the publics are influenced most by the crisis, different strategies of apologia will be more effective.

Apologetic strategies

In their leading apologia research, Ware and Linkugel (1973) outline four basic responses, available to apologists (Hobbs, 1995): denial, bolstering, differentiation, and transcendence. These strategies have now been incorporated into the study of organizational rhetoric. Denial and bolstering are considered reformative strategies in that they seek only to change the “cognitions” of the publics and not the meaning the mistake has created for the publics involved (Hobbs, 1995). In using denial, organizations are attempting to completely renounce their relationship to mistakes the publics involved find unfavorable. Bolstering allows the organization to distance itself from the unfavorable mistake by allying itself with something the public finds favorable. Transformative strategies (differentiation and transcendence) extend the reformation in that they alter the mistakes meaning and how the organization is attempting to fix it. Differentiation allows the organization to remove itself from “the negative context of the situation,” while transcendence places the organization in an often value-oriented and abstract positive context (Ware & Linkugel, 1973, p. 280).

In order for apologia to be most effective, some researchers argue, it should combine one reformative and one transformative strategy. This combination creates what is known as the four postures (Ware & Linkugel, 1973). Absolution (a combination of denial and differentiation) seeks to “acquit” the organization from the negative charges (Hobbs, 1995). Denial and transcendence account for the vindication posture or the upholding of the organization’s values, especially compared to the organization’s accusers. Explanation (bolstering and differentiation), based on the belief that an understanding will prevent the publics’ denunciation, offers the publics a correct understanding of the organization’s stance. Finally, justification utilizes bolstering and transcendence to seek not only the understanding gained from explanation, but acceptance as well.

Method

In order to effectively analyze Chi-Chi’s crisis, the application of theory and context were useful in order to complete a rhetorical analysis of the newspaper articles, press releases, and interviews connected with the crisis. In this particular case, rhetorical analysis allowed for the examination of the messages of the various publics involved with Chi-Chi’s and the apologia the corporation utilized with their publics. To provide a theoretical background for this case study, a bank of various articles from communication and public relation journals were compiled and developed into the previous literature review. These articles provided the apologetic categories (denial, bolstering, differentiation, and transcendence) for analysis, to determine whether or not Chi-Chi’s rhetorically succeeded in their apologetic strategy.

Approximately 100 newspaper articles were gathered, primarily from *The Patriot News* and the *Pittsburgh Post-Gazette*, local Pennsylvania papers reporting on the outbreak, and various national and international papers

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using *Associated Press* releases to cover the story. These sources were dated from September 2003 to July 2004. Enhancement pieces, press releases, and national advisories from government agencies added depth to the newspaper sources.

Analysis

Pre-Crisis

By November 2003, Chi-Chi's had been linked with the largest single source Hepatitis A outbreak the nation had ever experienced (Srikameswaran, 2003). Throughout August and September numerous states, including Georgia, West Virginia, North Carolina, and Tennessee, reported over 500 Hepatitis A cases, including 82 traced to a single restaurant in Tennessee (Mandak, 2003b). By late September and early October, green onions had been identified as the cause ("Investigators probe," 2003). The latest outbreaks, however, were not the only ones linked to green onions. In 1998, green onions from two firms in Mexico and one in California were linked to a Hepatitis A outbreak in Ohio, although the actual source is still unclear.

Because Hepatitis A has a relatively lengthy incubation period of fifty days, it is frequently difficult to identify the disease's source (Boodman, 2003). In fact, the Federal Department of Agriculture (FDA) and Centers for Disease Control and Prevention (CDC), along with various state health departments, state that usually only half of all reported Hepatitis A outbreaks are ever linked with a source ("Investigators probe," 2003).

Green onions tend to harbor the disease because their multi-layered nature makes cleaning difficult. Because of this, no effective cleaning procedures standards exist in the restaurant industry ("We're safe," 2003). However, the FDA has established "voluntary [cleaning] guidelines for fresh fruit and vegetables" (Mandak, 2003c).

Food safety investigators and experts note that only two percent of all imported food is inspected as it crosses the border (Boodman, 2003). While Chi-Chi's uses green onions in many of its salsas, dips, and entrees, it ships fresh green onions to its restaurants to make mild salsa and cheese dip in-house. Hot salsa is manufactured offsite. The green onions arrive in 8.5-pound boxes packed in ice and are stored for at least five days after they arrive. While the green onions are stored, the ice melts and creates a soup comprised of the melted water and onions. The onions are then rinsed, machine-chopped, and refrigerated for an additional two days, after which they are mixed into forty- to eighty-quart buckets of mild salsa. While the onions have been already stored for a minimum of seven days in this procedure, the mild salsa itself has been stored for up to ten days, which creates a storage time for the onions of up to seventeen days (Boodman, 2003). Even though the Hepatitis A virus could not have been cleaned from contaminated onions, even with chlorine, through "prolonged soaking in contaminated ice, the virus probably seeped deep inside the onions" making the virus more toxic (Drexler, 2003).

Between mid-September and mid-October 2003, eleven thousand customers dined at the Beaver Valley Mall Chi-Chi's in Pennsylvania (Roddy et al., 2003). The first Hepatitis A victim reportedly ate at this Chi-Chi's restaurant around 20 September (Snowbeck, 2003a). However, most of the victims ate at the restaurant between 3 October and 6 October, with the latest victim visiting Chi-Chi's on 18 October (Snowbeck, 2003d). Even though most of the victims of the illness ate at the restaurant in October, the outbreak was not confirmed until 3 November 2003 ("Officials say outbreak," 2003). Because

of hepatitis' lengthy incubation period, many victims did not demonstrate symptoms of the illness until mid-October. The first patient, in fact, did not enter the hospital until late October.

Crisis

During November 2003, Chi-Chi's and the Hepatitis A outbreak dominated local and national headlines. Besides news of the potential causes of the outbreak, there were reports of three deaths related to the disease. On 3 November 2003, Pennsylvania health officials announced the threat of a Hepatitis A outbreak linked to the Chi-Chi's Beaver Valley Mall restaurant ("Third death reported," 2003). Due to growing suspicions as to the disease's cause, Chi-Chi's voluntarily closed the restaurant doors to limit the virus outbreak (Chi-Chi's, Inc., 2003c). Because the impact of Hepatitis A can be drastically reduced, if not eliminated, if potential victims receive the inoculation within fourteen days of contact, Pennsylvania and Beaver County health departments opened an immune goblin clinic on 5 November 2003, in an effort to contain the disease. While the Hepatitis A victims count was at 84, with 2,400 people receiving immunizations on the opening day of the clinic, the number of infected rose to 130 the following day, with a total of 2,800 people receiving immunizations (Lin, 2003; Snowbeck, 2003d). The count of infected victims was up to 510 in mid-November, including thirteen of the Beaver Valley Mall Chi-Chi's employees (Wahlberg, 2003; "Investigators probe," 2003). By the end of November, the hepatitis case count had reached 635, those screened for the virus had reached 10,000, and those immunized had reached 9,100 ("Restaurant hepatitis toll," 2003). Also, by the end of November, the outbreak had claimed the lives of John Spratt, age 46, Jeff Cook, age 38, and Dineen Wieczorek, age 51, all of who had eaten at Chi-Chi's in the previous weeks.

The infected Chi-Chi's employees played an integral role in the determination of the cause of the outbreak. At the onset of the crisis, many thought Chi-Chi's unsanitary practices were the cause. However, when Chi-Chi's employees fell ill to the disease simultaneously with other victims, health officials noted that it was unlikely that Chi-Chi's had an immediate role in the spreading of hepatitis (Wahlberg, 2003).

After interviewing 207 victims who ate at the restaurant, research showed 98% had eaten mild salsa or cheese dip (Mandak, 2003b). By 10 November 2003, green onions were suspected as the correlating factor in what was reportedly the largest single-source hepatitis outbreak in United States history ("Health officials link," 2003). Similar outbreaks in Georgia, North Carolina, West Virginia, and Tennessee also assisted researchers in locating the source. While it took eighteen days to determine green onions' role in similar outbreaks, health officials took approximately twenty days to fix the blame on green onions at Chi-Chi's ("Investigators probe," 2003; Snowbeck, 2003d).

On 15 November 2003, the FDA issued a national warning; cautioning people to eat only cooked green onions (Mandak, 2003b). Once green onions were officially determined to be the source of the hepatitis, Chi-Chi's, Taco Bell, TGI Friday's, Baja Fresh, and Acapulco, and El Torito Restaurants, removed green onions from their menus nationwide ("Third death reported," 2003; "Hepatitis scare crimps," 2003; Pennino, 2003; Prendergast, 2003). Even after green onions had been identified as the cause, investigators had difficulty determining the initial source of the outbreak (Mandak, 2003d). However, by 19

The infected Chi-Chi's employees played an integral role in the determination of the cause of the outbreak.

November 2003, health officials strongly suspected that infected green onions caused the outbreak from Mexico; however, the names of the Mexican firms were not released (Snowbeck, 2003c). Around this same time, the Mexican government closed down four companies operating eight firms that exported green onions to the United States. Again the names of the companies were not released (Snowbeck, 2003e).

On 21 November 2003, due to these growing suspicions, the United States halted imports of Mexican green onions. In a conference call between the FDA and Mexico's Ministry of Agriculture, four companies were linked with "deficiencies in agricultural processing" and as potential sources of the recent Hepatitis A outbreak. The firms named were Dos M Sales, Agro Industrias Vigor, Tecno Agro International, and Agricola La Guna (Lindquist, 2003b). Investigators also linked four United States green onion distributors with the hepatitis outbreak, including Castellini Company of Wilder, Kentucky; Newston Fresh Foods, LLC of Salinas, California; Apio Fresh, LLC of Guadalupe, California; and Boskovich Farms, Inc., of Oxnard, California ("Couple sues four distributors," 2003).

In early December, three FDA officials, one CDC official, and four Mexican government officials began investigating the Mexican firms to determine if negligence was to blame for the outbreak (Snowbeck, 2003f). During the investigation, the Mexican government accused the United States of being irresponsible in naming the growers without proof, claiming food grown in Mexico was every bit as safe as that grown in the United States (Lindquist, 2003a). These contradictions continued as the Mexican government's inspections of the Mexican firms found problems only at three of the four firms, while the United States discovered problems at all four. The largest concern arose at the Dos M Sales plant owned by United States citizen Michael Brazel and located west of Mexicali outside of La Rumorosa. Investigators suspected that untreated water from a small dam was used for sanitation purposes at Dos M Sales. The investigators found the following to be areas of concern throughout the Mexican plants: poor sanitation, inadequate hand washing facilities, worker health and hygiene, quality of irrigation water, and the ice and materials used for packing the green onions (Lindquist, 2003b).

Due to its recent bankruptcy, Chi-Chi's was working with bankruptcy courts seeking access to money to pay the medical bills of virus victims who were suing Chi-Chi's. However, with the discovery of the onion firms' connection to the outbreak, some of the lawsuits were dropped against Chi-Chi's and filed against the green onions growers and distributors. One distributor, the Castellini Company, responded to these accusations by claiming that other than moving them from one truck to another they were not involved with transporting infected green onions ("Wilder, K. Y. firm sued," 2003).

On 10 December 2003, the courts established the guidelines for Chi-Chi's to follow in payments to victims. These guidelines allowed Chi-Chi's to pay out-of-pocket claims up to \$3,000; however, claims of between \$3,000 and \$20,000 were to be reviewed by insurance companies and those greater than \$20,000 were to be approved by the bankruptcy court (Mandak, 2003e).

By the end of November, the CDC believed the outbreak was winding down. At its peak in early December, the count of those infected had reached 635 ("Restaurant hepatitis toll," 2003). However, on 12 December 2004, letters were sent home to parents from the Beaver County school district, notifying them that two students were diagnosed with Hepatitis A (Srikameswaran, 2003). The two student cases were among ten secondary hepatitis cases resulting from close contact with those that had the initial strain of Hepatitis

A (Snowbeck, 2003g).

Post-crisis

On 15 January 2004, the Beaver Valley Mall Chi-Chi's reopened to lines of excited patrons (Fuoco, 2004), but the outbreak continued to affect Chi-Chi's many constituents, despite the rejuvenation of the Beaver Valley Mall location. "Hepatitis claims?" advertising for Hepatitis A litigation appeared on billboards throughout Beaver County, and state and federal agencies were just beginning to understand the outbreak's economic toll (Sentementes, 2004).

The Chi-Chi's outbreak had an enormous impact on the restaurant and food industries throughout the nation. When Chi-Chi's pulled green onions from their menu in mid-November, they were closely followed by Taco Bell, TGI Friday's, and various other restaurants, who also removed green onions from their locations throughout the nation ("Hepatitis scare crimps," 2003; Pennino, 2003; Prendergast, 2003). Independently-owned Mexican restaurants in the Pittsburgh area saw a reduction in their sales and patronage due to fear of hepatitis, although none was as severe as Chi-Chi's experience (Fitzpatrick, 2003; Mandak, 2003d). Grocery stores also saw a drop in sales of green onions, so much so that some grocers threw away \$2,000.00 worth of green onions from their stores ("Green onion sales," 2003; McNulty, 2003).

While the economic impact of the Chi-Chi's outbreak itself was detrimental, the outbreak also stimulated conversations about food handling procedures, most of which were in Pennsylvania. The Allegheny County Health Department suggested that restaurants place disclaimers on their menus about raw and/or undercooked produce similar to warnings about raw/undercooked meat (Nepkin, 2003). These warnings, health officials said, would assist in protecting of restaurants and their consumers from food-borne illnesses. Because of theirs and the National Restaurant Association's belief that these warnings would prove beneficial, the Allegheny County Health Department planned to implement these warnings at the start of 2004. The restaurant industry also returned to the discussion of requiring food handlers to wear gloves. While all restaurant employees are required to wash their hands prior to handling food, many managers did not believe gloves would aid in eliminating the spread of food-borne illnesses (Gleiter, 2003). However, after the outbreak, more restaurants and grocers were beginning to use gloves in order to enhance safety procedures.

The hepatitis outbreak had a strong impact not only on the food industry, but also on local, state, and national health departments. While most states average 159 health workers for every 100,000 people, Pennsylvania only has 37 for every 100,000, or a total of 4,465 for the entire state ("State ranks last," 2003). However, even with a limited staff was stretched to its limits, the Pennsylvania Department of Health still managed to provide over 10,000 hepatitis screenings and 9,100 inoculations. The Pennsylvania Department of Health declared that 130 of 660 who were infected with hepatitis required hospitalization, generating a grand total of hospital bills at \$1.2 million (Fitzpatrick, 2003; Sentementes, 2004). Each immune globulin shot cost \$15, bringing the total cost to the state health department to \$136,000 in shots alone. According to data collected from previous outbreaks, it is estimated that average expenses for each hepatitis victim range from \$1,817.00 to \$3,837.00. Because the Pennsylvania outbreak was so severe, the total health care costs

The Chi-Chi's outbreak had an enormous impact on the restaurant and food industries throughout the nation.

far exceeded the \$2.25 million spent in the 1997-1998 Spokane, Washington, Hepatitis A outbreak (Fitzpatrick, 2003). These figures also do not account for the costs incurred to investigate the outbreak on the national level.

Bill Marler, attorney for many Pennsylvania hepatitis victims, estimated in November 2003 that a total cost of \$100 million would be likely after all medical charges, lost wages, and emotional stresses were taken into account (Fitzpatrick, 2003). By mid-February of 2004, 200 claims totaling close to \$1 million had been filed against Chi-Chi's, seventy-five percent of which had been paid (Mandak, 2003a). On 23 February 2004, a judge approved the mediation system so that lawsuits could be filed against Chi-Chi's, which was in the middle of bankruptcy (Johnson, 2004). While payment to victims was perhaps the largest expense incurred, Chi-Chi's also had the expense of paying the Beaver Valley Mall location employees until the restaurant reopened in January (Chi-Chi's, Inc., 2003a).

Analysis

While many of the attorneys and victims in the Chi-Chi's case did not feel that Chi-Chi's responded quickly enough or appropriately, some experts, including Randy Hiatt, a restaurant analyst, believed Chi-Chi's responded in the best manner possible. In order to handle the crisis, Chi-Chi's appointed a single high-level company officer, Chi-Chi's CEO Bill Zavertnik, to manage public relations during the crisis. In so doing, Chi-Chi's hoped to be open with its publics and to confront the crisis directly.

Chi-Chi's did not comment formally on the hepatitis outbreak until 7 November 2003, four days after the outbreak was confirmed at the Beaver Valley Mall location. Initially, many believed unsanitary practices in the Beaver Valley Mall Chi-Chi's was responsible for the outbreak. At this time Chi-Chi's noted that six of its employees had contacted Hepatitis And took responsibility in its statement:

We sincerely apologize to all of our loyal customers and want to inform the community that Chi-Chi's will do everything within our power to make sure that our patrons continue to enjoy a healthful and rewarding dining experience and that our employees have a safe and sanitized working atmosphere. (Chi-Chi's, Inc., 2003a)

Two other responses from Chi-Chi's (on 11 & 12 November 2003) further illustrate Chi-Chi's proactive response to the crisis. Chi-Chi's hired medical consultants to work with the CDC and FDA to identify the cause of the outbreak, voluntarily removed green onions from its menus, and closed the Beaver Valley Mall location. Chi-Chi's greatest concern was how to assist infected customers with medical expenses and lost wages, and how to compensate employees while the Beaver Valley Mall location was closed. In order to begin dealing with these concerns, Chi-Chi's established a toll-free number for concerned victims and employees. Chi-Chi's remained firm in defending its outstanding record with health inspections and their long record of upholding health and safety in their restaurants to ensure the finest dining experience possible (Chi-Chi's, Inc., 2003b).

To this point, Chi-Chi's mainly used the apologetic tactic of bolstering in an attempt to distance the organization from the crisis by citing positive actions it had taken while emphasizing its outstanding safety and health records. By utilizing this tactic, Chi-Chi's acknowledged that it had failed but was trying to respond as diligently and effectively as possible. This was an appropriate tactic since denial of the outbreak and Chi-Chi's involvement in it would only

have discredited the restaurant's reputation and distanced the organization from its customers and creditors. As a reformatory strategy, bolstering allowed Chi-Chi's to interact with all of its publics in assuming a responsible, moral position in the crisis and actively demonstrated Chi-Chi's good faith and its efforts to help those affected by the outbreak.

On 21 November 2003, green onions were officially declared to be the cause of the outbreak. As a result of investigations by the CDC and the FDA, Chi-Chi's was freed from the accusations of blame many had harbored at the commencement of the outbreak. While Chi-Chi's did mention the organization's relief in its exoneration, it never accused or confronted the distributors who were to blame for the infected green onions. As the crisis waned and distributors and growers were named, Chi-Chi's continued its use of bolstering and transcendence, stressing the organization's values, to retain its publics' respect. In doing so, Chi-Chi's was able to justify its position, emphasizing that it was, in fact, through the organization's own efforts that the cause of the outbreak was identified.

As claims for financial assistance with medical expenses and lost wages continued to mount, Chi-Chi's lawyers decided the growers and distributors of the tainted green onions should also be involved in victims' reimbursements (Mandak, 2004). While Chi-Chi's could easily have transferred fault and responsibility to the growers and distributors involved in the crisis, it instead sought a partnership so that all those bearing some responsibility for the crisis (whether large or small) would be involved in assisting crisis victims. Chi-Chi's took the higher road in its approach, recognizing that the organization could not have prevented the outbreak but still accepting responsibility for the restaurant's indirect role. It is interesting to note that many of the distributors and growers involved in the outbreak either did not respond publicly or directly denied their involvement in the crisis. The Mexican government also responded to the accusations with denial, believing that the food produced in Mexico was just as safe as that produced in the United States.

Most of the outbreak-related litigation took place between February and July 2004, and was expected to consume most of Chi-Chi's \$51 million liability insurance (Mandak, 2004). Faced with an onslaught of victims' claims, Chi-Chi's desperately needed the financial assistance of other responsible parties (distributors and growers). In mid-April, Chi-Chi's lawyers began to put more pressure on suppliers in order for Chi-Chi's to maintain its responsibility to its creditors as well as the victims. One year after the outbreak, litigation continues.

Conclusions

Where Chi-Chi's failed

- While it was important for Chi-Chi's to accept responsibility for the outbreak, Chi-Chi's justificatory response did not place enough responsibility on the onion suppliers.
- Had Chi-Chi's been more forceful with the green onions distributors and growers of the at the beginning of the litigation process, it would have had been better equipped to maintain its financial responsibility to its enabling publics.

Where Chi-Chi's succeeded

- Chi-Chi's maintained an aggressive approach, voluntarily closing its restaurant and removing green onions from the menu.
- Chi-Chi's justificatory apology provided a moral approach resulting

in many faithful customers returning to the reopened Beaver Valley Mall Chi-Chi's.

What Chi-Chi's learned

- Accepting responsibility and responding to the crisis is imperative; however, organizations should not assume all responsibility if other parties are involved.
- Being honest with one's publics is the best approach to handling a social legitimacy crisis.
- While integrity is important when confronting crises, responding directly to the public at the onset of the crisis instead of waiting three weeks to hold the first press conference would have been a more successful strategy.

Implications For Best Practices

The Chi-Chi's crisis supports apologetic research suggesting that when food safety is involved blending one reformative strategy and one transformative strategy produces the most effective public response. Chi-Chi's use of bolstering and transcendence proved successful with the majority of its publics. Justification allowed Chi-Chi's to maintain its integrity as a food service while explaining the crisis to all of its publics. In order to most effectively handle a crisis, it is important that all responsible parties work together to assume responsibility and share in its resolution. Furthermore, direct response to the press and public will demonstrate honesty and the desire to amend the situation as quickly as possible.

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Chapter

4

**Jack in the Box:
Lessons Learned
by Accepting
Responsibility**

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Food-borne crises facing restaurants, food distributors, and meat-packing plants involves bacterial contamination with resulting public health problems. One such crisis began on 5 January 1993, when an outbreak of *E. coli* 0157:H7 in Seattle, Washington, was eventually linked to hamburgers served at Jack in the Box restaurants. Only a minute amount of *E. coli* carried by a variety of foods, including raw meat and poultry, is enough to make a person sick, and according to estimates, millions of people are infected annually. For most people, the result is a few days of diarrhea, nausea, and vomiting. However, these infections can cause “kidney failure, bloodstream infections and even death” (Morris, 1993). On January 13, Children’s Hospital alerted the Washington Health Department that its doctors were treating a large number of children with *E. coli* infections (“Jack in the Box’s worst nightmare,” 1993). Within a month, three were dead and the health of nearly 400 people in Washington was compromised (Gilmore & Lewis, 1993).

Once the outbreak was linked to Jack in the Box, Foodmaker, Inc., officials responded ambiguously to the crisis by defending their cooking practices and expressing concern for customers, but deflected blame to other entities as the cause of the problem.

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Inc., officials responded ambiguously to the crisis by defending their cooking practices and expressing concern for customers, but deflected blame to other entities as the cause of the problem. Even when the Health Department found evidence that the hamburger meat was not cooked to the state approved temperature, Foodmaker, Inc., officials shifted the blame to the inspectors for the results they found. Eventually, Foodmaker, Inc., was forced to address specific improper cooking practices and apologized for its part in causing the outbreak of *E. coli*.

Research Questions

In an effort to understand what happened during this food crisis, this chapter explores the pre-crisis, crisis, and post-crisis actions taken by Jack in the Box and its parent company Foodmaker, Inc., and addresses the questions:

- Why did Foodmaker, Inc., change its communication strategy when dealing with the *E. coli* crisis resulting from the sale of undercooked hamburgers at Jack in the Box restaurants in Seattle, Washington?
- What organizational lessons did Jack in the Box and Foodmaker, Inc., learn as a result of this crisis?

Crisis Timeline

Three phases of the crisis are identifiable. The pre-crisis phase began 10 years before the 1993 crisis, when *E. coli* was found to be the source of food poisoning as several children became ill in Washington State. The pre-crisis continued until 1993, when a group of children were hospitalized in the Seattle area, prompting health officials to investigate. The crisis phase continued from this point until Foodmaker, Inc.’s, annual meeting, when Jack in the Box and Foodmaker apologized and changed their public communication about the crisis. The post-crisis began in mid-February and continued to the end of the year as company spokespeople implemented what they hoped would be specific

strategies to effectively regain their customers and to build the goodwill of the franchisees.

Pre-Crisis Phase

| | |
|------------------|---|
| 1982 | First E. Coli outbreak identified |
| 1986 | Last major outbreak (before the current crisis) of E. coli strain at fast food restaurant in Walla Walla, Washington. |
| 24 Sept 1990 | Article in Supermarket News, a trade publication mailed to distributors like Vons, specifically calls attention to E. coli. |
| 1992 | Jack in the Box opens 63 restaurants, plans to open another 70 in 1993, including 12 in Washington. |
| March 1992 | Jack in the Box touts quality control measures and high cooking standards when it offers stock and solicit investors. |
| 1 May 1992 | Washington raises standards to 155 degrees. |
| 19 November 1992 | Production of 193 cases of contaminated hamburger by Vons. |

Crisis Phase

| | |
|----------------|--|
| 5 January 1993 | Outbreak begins in Seattle, Washington, area. |
| 13 January | Start of crisis; Children's Hospital alerts Washington Health Department of large number of children with E. coli. |
| 15 January | Jack in the Box aware of the outbreak |
| 18 January | Jack in the Box publicly linked to outbreak; Jack in the Box stops selling hamburgers in Washington state |
| 19 January | Jack in the Box replaces 28,000 pounds of meat; resumes sales; switches to 155 degree temperature for cooking |
| 22 January | First death; two-year-old in Tacoma |
| 25 January | First law suits filed |
| 27 January | Jack in the Box still not cooking hamburger at regulation temperature |
| 28 January | Second death ("Bacteria claim another child, 1993) |
| 4 February | Foodmaker lawsuit filed against suppliers |
| 12 February | Foodmaker, Inc., apologizes; fires Fleishman-Hillard |

Post-crisis Phase

| | |
|-------------|---|
| 20 February | Third death ("Third person dies....," 1993). |
| 23 February | Epidemiological evidence uncovered that meat passed through deboning plant in Los Angeles on 18 November 1992 |
| 11 March | Heavy discounting and renewed advertising begins |
| 26 March | Lawsuit settled; identification of larger problem |
| 28 March | 30 of 90 slaughterhouses shut down nationwide |

Theoretical Underpinnings

Organizational learning theory provides insight as we seek to understand how Jack in the Box and Foodmaker, Inc., dealt with the crisis. When faced with a crisis, “organizations . . . must be open to new insights, understanding, and skills while maintaining the knowledge, skill, and wisdom that have proved successful” (Seeger, Sellnow, & Ulmer, 2003, p. 36). Sitkin, Sutcliffe, & Weick (1999) defined this as “a change in the organization’s enacted response repertoire” (p. 7). In this instance, once facts about the cause of the outbreak became public, Jack in the Box came to realize that its strategy—deflecting blame and providing

Crisis communication specialists suggest that Jack in the Box and Foodmaker, Inc., might have been better prepared to deal with the outbreak and its aftermath had a crisis plan been in place.

major discounts to entice people to eat at the restaurants—could not be maintained. To reestablish its credibility with stockholders and promote acceptance by the public, Jack in the Box had to change its response in order. This awareness is consistent with what Seeger et al.

(2003) described as the processes of learning: “It emphasizes system openness and flexibility as essential for accommodating changing conditions and for new understanding of existing conditions. By learning, the organization adds new know-how, competence, skills, and capacity” (p. 37). In the case of Jack in the Box, when cooking procedures were found to be the cause of the undercooked meat, management instituted a training program to assure the public that steps were being taken to make certain that the crisis would not be repeated. When the public relations strategy failed, the company fired its public relations agency, apologized, and accepted responsibility for the crisis.

Crisis communication specialists suggest that Jack in the Box and Foodmaker, Inc., might have been better prepared to deal with the outbreak and its aftermath had a crisis plan been in place. According to Seeger et al. (2003), “The fundamental function of a crisis plan is to reduce risk and help an organization respond to crisis in a timely and effective manner” (p. 166). When a crisis occurs, the need to identify the source of the problem, to identify a plan to correct the problem and contain the crisis, and to communicate quickly with a variety of groups, can overwhelm an organization. As Seeger et al. (2003) continue: “a crisis often results in inconsistent and delayed responses, maladaptive reactions, failure to contain and reduce the harm, an extension of the crisis stage, adversarial relations with stakeholders, and a protracted and damaging postcrisis stage” (p. 166). The absence of a crisis plan affects how an organization responds ethically to a crisis situation. As Seeger (1997) contends, when organizations confront a crisis situation without a crisis plan, dissension occurs over which values should dominate in a particular situation and the potential for making an unethical decision increases.

As the crisis unfolded, organizational learning and a crisis plan proved to be the characteristics needed by Jack in the Box and its parent company, Foodmaker, Inc. As management attempted to orchestrate ambiguous responses to health officials, patrons, and stockholders, the absence of a crisis plan limited Jack in the Box’s and Foodmaker, Inc.’s, ability to keep the restaurant chain blameless. In the end, the corporate leaders and the entire organization learned their lessons publicly as they were forced to shift from deflection to acceptance of blame.

Method

The data base for this chapter is drawn from 48 news articles published

during 1993 in national and major regional newspapers covering Seattle, Washington, and the surrounding area. The *Lexis-Nexis* database located these articles, which were subsequently downloaded and analyzed. The articles range in date from 19 January to 31 December 1993.

For this case study, a close textual analysis of the news articles revealed stages of the crisis, enabling the application of theory associated with pre-crisis, crisis, and post-crisis stages of crisis management. The accuracy of the information presented in the early stages of the crisis was verified in later accounts. The application of organizational learning due to the apparent absence of a crisis management plan provides insight into how Jack in the Box spokespeople communicated with the public and with various groups of stakeholders.

Analysis

Pre-Crisis Phase

The outbreak in 1993 was not the first one in the state of Washington. After two E. coli outbreaks in the 1980s, the Washington Health Department decided the quality of the meat products being distributed within the state could not be controlled. However, by increasing the cooking temperature of meat at restaurants, 99.99% of the most harmful bacteria in the meat could be destroyed (Blake, 1993). After much debate, in 1992 the department raised its cooking standards and required restaurants to cook hamburgers to an internal temperature of 155 degrees, replacing the old 140 degree rule which was the standard used in most states. Although Jack in the Box and its parent company, Foodmaker, Inc., claimed not to have been informed about this change, company spokespeople later acknowledged they had been notified. In fact, while the area's Jack in the Box restaurants had been routinely checked by the Seattle-King County Health Department "for inadequate refrigeration, rodents and other health hazards," hamburger temperatures were only checked on five of 134 inspections in 1991 and 1992 ("Inspectors rarely tested hamburgers for undercooking," 1993).

Jack in the Box had been in business for 42 years at the time of the outbreak. In 1992, the restaurant had opened 63 new establishments and planned to open another 70 in 1993, 12 of which were to be in Washington ("Jack in the Box's worst nightmare," 1993). The company presented itself as a growing, successful organization to its stockholders and took pride in describing itself as a safe investment.

Crisis Phase

As soon as Jack in the Box became aware of the crisis, the corporation took action to deal with the situation. First, by 19 January Jack in the Box had replaced 280,000 hamburger patties ("Meat seized in poisoning," 1993), halted hamburger sales in the state of Washington by January 20 ("Foodmaker shares dive Seattle," 1993), checked all grills to be sure they were operating at a proper temperature ("Jack in the Box says it will pay," 1993), and changed meat suppliers for its restaurants in Washington and Idaho by the end of the month (McCullough, 1993). In addition, Jack in the Box retrained its grill operators to cook meat more thoroughly, opened a toll-free number for consumers, and expressed deep regret to the public (McCullough, 1993). Jack in the Box agreed to pay all hospital bills for victims (Sanchez & Greenhill, 1993; Moriwaki & Kusumoto, 1993). The chain also contributed a sizable donation to help find

Jack in the Box quickly responded publicly upon learning of the crisis, with company spokespeople asserting that the blame for the outbreak should fall on other entities.

a cure of the E. coli infection (“Jack in the Box’s worst nightmare,” 1993). To further guarantee the safety of the hamburgers, after it reopened the Mercer Island Jack in the Box took the temperature of every hamburger coming off the grill and reported the results of the health department (Nelson, 1993).

Jack in the Box quickly responded publicly upon learning of the crisis, with company spokespeople asserting that the blame for the outbreak should fall on other entities. Robert Nugent, president of Jack in the Box, announced:

“In the last 10 years, we’ve sold 400 million pounds of hamburger safely and without incident. Then, bang, it hits you. It’s your worst, worst nightmare” (“Jack in the Box worst nightmare,” 1993). When the fast-food chain stopped selling all hamburger products by noon on 19 January 1993 and replaced its hamburger supply

(“50 poisoned by burgers,” 1993), Sheree Zizzi, spokeswoman for Foodmaker, Inc., expressed the company’s concern about the outbreak and its willingness to find the cause of the problem. To deflect potential blame, she stressed that employees were being contacted “to be sure the food is properly prepared and cooked” (Kusumoto, 1993). Zizzi commented on January 28, “We haven’t seen the Health Department report, but rest assured we’ll be investigating it fully. Our procedures clearly outline proper hygiene, food storage, and cooking in accordance with state standards” (Williams & King, 1993, p. A1).

Over the next few weeks, company spokespeople reiterated that they followed appropriate food preparation guidelines, often suggesting that undercooked hamburger was the fault of others. Company president Robert Nugent repeatedly stated that Jack in the Box increased its cooking times to exceed federal and state requirements (“Jack in the Box says it will pay. . .,” 1993). At one press conference, Nugent blamed the health inspectors for the undercooked hamburger: “It’s my belief that the health inspectors from King County were not, in fact, allowing our employees to exercise the cooking procedures. . . . They didn’t let him finish [before they inspected for undercooked meat]” (Nelson, 1993).

To further the perspective that Jack in the Box was not the cause of the problem, and to build good will with the public, Jack in the Box Chairman Jack Goodall said, “The company extended its prayers and sympathy to the families affected” (Angelos, 1993, p. C1). Within a week, the company announced it would pay hospital bills for all customers stricken with E. coli bacterial intestinal disease. Robert Nugent said, “Costs will be paid ‘no strings attached’” (Gilmore & Lewis, 1993). A special hotline number was established for people to call if they thought they were infected (“Jack in the Box says it will pay . . .,” 1993). Later, the company explained that by accepting assistance, people were not “signing away their right to file suit later” (“Jack in the Box says it will pay. . .,” 1993, p. A6). Throughout the crisis, Nugent said the company would do the morally right thing.

Foodmaker, Inc., through its statements and actions, shifted the blame from Jack in the Box to its suppliers. Robert Nugent, President of Jack in the Box, stated: “The outbreak of food-related illnesses in Washington over the past two weeks has required us to re-evaluate all our suppliers, processors and quality control procedures throughout the system” (McCullough, 1993, p. 4B). Foodmaker also filed a law suit against Vons Companies, Inc., and its other suppliers, seeking to recover all of the costs resulting from the outbreak of E.

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coli 0157:H7 (Gilmore & Lewis, 1993). Later, Jack in the Box acknowledged that “its contract did not call for Vons to test the meat” (“Jack in the Box worst nightmare,” 1993).

The economic impact of the crisis for Jack in the Box and Foodmaker, Inc., began on 20 January, when Foodmaker shares fell \$1.50, or 11% on the New York Stock Exchange (“Foodmaker shares dive Seattle,” 1993). Jack in the Box restaurants referred all questions from reporters to the corporate officials in San Diego, “which did not return calls” (Nogaki, 1993). While Washington accounted for only 6% of Jack in the Box’s cash flow, sales continued to fall “though the company will not say by how much” (“Jack in the Box’s worst nightmare,” 1993). Later reports documented that “by the first week in February, [sales] were down 40% from the comparable 1992 period” (Sims, 1993).

Foodmaker, Inc., chairman Jack Goodall offered “our deepest sympathy and most heartfelt apologies” and “we’re very sorry” which was the first time an apology for causing the crisis had been acknowledged.

Throughout the crisis, company spokespeople downplayed the economic impact (“Jack in the Box sales expected to rebound,” 1993). According to Zizzi, “Sales have been secondary to us” (“Jack in the Box says it will pay. . .,” 1993). As Foodmaker, Inc., and Vons, the nation’s ninth-largest supermarket chain, became implicated, shares in their company dropped. Foodmaker lost about one third of its value in January (Flores, 1993) and Vons stock went down \$2 on the NYSE Big Board immediately after the outbreak (Chambers, 1993). While the outbreak represented an economic loss for the companies, there were other associated costs. Mimi Fields, Washington’s health officer, estimated the cost medical and governmental costs of the crisis at \$1 million and said, “the cost of grief to the families . . . is incalculable” (Chambers, 1993).

Post-Crisis Phase

At the beginning of the post-crisis stage, several statements made and actions taken at the Jack in the Box annual meeting in San Diego marked a change. Nugent conceded “he had been wrong when he insisted that the Washington State Department of Health had not notified the company last year of new, more stringent hamburger cooking regulations.” Foodmaker, Inc., chairman Jack Goodall offered “our deepest sympathy and most heartfelt apologies” and “we’re very sorry” which was the first time an apology for causing the crisis had been acknowledged. Foodmaker announced that “to ease the concern of investors, the company would draw from a \$50 million line of credit and use the \$100 million liability insurance policy to protect itself from claims,” and the corporation discontinued its relationship with the public relations firm Fleishman-Hillard, Inc., of St. Louis (Nogaki, 1993).

Families of the victims and franchisees sued Foodmaker, hoping to recover their losses. The comments of Sheree Zizzi, spokeswoman for Foodmaker when the suit of Riley Detwiler, one of the victims, was settled reflected a business-like tone, “We’re pleased to have resolved this matter. We believe the settlement was fair and equitable” (“E. coli parents settle suit,” 1993). Foodmaker official Robert Nugent was less pleased when commenting on the unsuccessful settlements with franchisees, “We are very disappointed that after extensive negotiations we were unable to resolve the matter in an amicable fashion.” Gina Devlin, a Foodmaker spokesperson, “declined to specify the terms or the number of restaurants affected” (Adelson, 1993). The main arguments of the franchisees were that Foodmaker, Inc., was negligent for failing to ensure that

the meat they supplied was safe (Harrison, 1993) and that the company was not forthcoming about information that later affected stock prices (Flores, 1993).

The economic impact on the nation's #5 fast food hamburger chain was severe. Foodmaker ran television and newspaper ads featuring Jack W. Goodall, assuring the public that the food was wholesome, that the company would pay all medical costs for customers who became ill from eating at its restaurant, and that a discounting plan was in place to "capitalize on the good will" of the people who wanted to eat at Jack in the Box but were afraid to go back (Sims, 1993). According to reports, "The company lost \$29.3 million in the quarter after the disaster, including \$8 million in financial assistance for franchisees and lower income rents and royalties. Sales were down 11% to \$217.3 million" (Harrison, 1993). The crisis also prompted Foodmaker, Inc., to scale back its plans for expanding Jack in the Box (Bryant, 15 February 1993). The crisis also affected the meat packaging industry. By May, 30 of 90 beef slaughterhouses were closed as part of a USDA review (Sugarman, 1993).

An analysis of sales at Jack in the Box is also revealing. When franchisees began suing Foodmaker, Inc., for their losses, the parent company suggested that the economic damage was not as severe as claimed. While sales did improve after the company acknowledged its responsibility and took corrective measures regarding the cooking temperatures, Mitchell Shapiro, an attorney for the franchisees who were suing, argued: "Some of the recovery is artificial. A lot of those sales are of heavily discounted items." Once the discounts and specials were phased out by Jack in the Box, sales fell by as much as 30% in some of the franchises (Harrison, 1993).

Conclusions

Although Dean Owen, a Washington Health Department spokesman, claimed on 19 January that the cause of the crisis had not yet been determined, it was not long until three sources were blamed: The United States Agriculture Department (USDA) and state health officials blamed Jack in the Box for not cooking hamburger at 155 degrees as required by state; Jack in the Box blamed its supplier, the Vons Companies of Arcadia, California, for supplying tainted meat; and Washington state health officials believed the meat was contaminated at the slaughterhouse ("Jack in the Box's worst nightmare," 1993).

USDA and State Health Officials blamed Jack in the Box for not cooking the hamburgers at the 155 degrees required by the state ("Jack in the Box's worst nightmare," 1993). Several factors contributed to placing blame on Jack in the Box. On 28 January, "Inspectors . . . found the grill was not working properly," cooking hamburgers at 13 to 17 degrees below the state-required 155 degrees; "health officials said the restaurant yesterday also had no soap and towels for work handwashing"; and "there was raw meat touching items such as lettuce that was not to be cooked" (Williams & King, 1993). Jack in the Box was clearly a factor in that 93% of those who became ill remember eating at a Jack in the Box, according to Dr. John Kobayashi, chief epidemiologist for the State Department of Health (King et al., 1993). The problem was especially serious for children: "smaller, children's burgers . . . are now considered a key culprit in the E. coli outbreak" [Thin patties sometimes curl up on a grill unless they are flattened with a press; they don't cook properly.] ("Inspectors rarely tested . . .," 1993).

Jack in the Box blamed Vons Companies for the crisis. As early as 29 January investigators isolated the Vons Companies of Arcadia as the source of the contaminated meat. Vons processed the meat on 19 November and

shipped it only to Jack in the Box restaurants (Glamser & Hoversten, 1993). Investigators found that 90% of the victims ate contaminated hamburger that could be traced to a shipment received from the Southern California Vons Companies. Federal agriculture officials said it occurred before the meat arrived at Vons and up to 14 slaughterhouses that might have provided meat to the distributor were being investigated (Gilmore & Lewis, 1993). Mary McAboy, a Vons spokeswoman attempted to deflect the criticism: “We continue to be confident that Vons’ processing did not contaminate the meat. Health authorities have made it clear that proper cooking would have prevented this tragedy” (Gilmore & Lewis, 1993).

Washington state health officials, with evidence provided by the Centers for Disease Control in Atlanta, suggested that meat contaminated at the slaughterhouse was responsible for the crisis. According to state officials, “The most likely source was meat contaminated with feces at the time of slaughter” (“Jack in the Box’s worst nightmare,” 1993). “Investigators . . . said yesterday that they have found ‘epidemiological evidence to suggest’ that the meat, infected with the E. Coli 0157:H7 bacterium, passed through the Service Packing deboning plant in Los Angeles on November 18. The deboning meat was then shipped to the Vons Company of Arcadia in Los Angeles County, which processed it into 40,000 hamburger patties and sold it to Jack in the Box restaurants in the three states where the food poisoning occurred” (Ingram, 1993). Of the nine sources of the meat for Service Packing, five are in California. The only Bay Area plant listed is Rancho Veal, Co., of Petaluma. To further focus on the slaughterhouses as the source of the crisis, “health officials said tests indicated there was no mishandling or refrigeration problems in the processing or transportation of the beef to Jack in the Box distribution centers” (“Jack in the Box’s worst nightmare,” 1993).

Some observers suggested that governmental agencies should have taken a more aggressive strategy when dealing with E. coli. An editorial in the *New York Times* gave the following perspective: “There are many ways the industry could lessen the risks of food poisoning, but the government does not require any of those steps, like microbiological testing to set bacterial standards for raw products. . . . the seal of approval on the meat it inspects is misleading” (Burrows, 1993).

Where Jack in the Box Failed

Jack in the Box, and Foodmaker initially did not handle the crisis effectively. According to Michael Brennen, vice president of Seattle-based public relations firm DeLauney Phillips, Inc., “Jack in the Box got off to a bad start because they first said they had no comment. . . . Then, they attempted to pass the blame to Vons. I would have advised them to step right up and accept responsibility” (Jack in the Box’s worst nightmare,” 1993). They also criticized “the Washington State health authorities for not informing the company of new cooking regulations” (Sims, 1993). These ambiguous, inconsistent and delayed responses suggested a failure on the part of Jack in the Box and Foodmaster, Inc., to contain and reduce the harm of the crisis.

James Lukaszewski, a crisis management consultant in White Plains claimed, “They were the model of doing things incorrectly” (Sims, 1993). Their

“Jack in the Box got off to a bad start because they first said they had no comment. . . . Then, they attempted to pass the blame to Vons. I would have advised them to step right up and accept responsibility.”

recovery strategy was two-pronged: “Convince patrons that the food poisonings were isolated incidents stemming from a single batch of tainted meat; and . . . offer customers an incentive” (Sims, 1993). Foodmaker’s dissatisfaction with the handling of the crisis may have precipitated the dismissal of its public relations firm, Fleishman-Hilliard Inc. of St. Louis. According to Sims (1993): “Foodmaker officials, who insisted on anonymity, said the restaurant company and the public relations firm had parted because of personality conflicts and disagreement over how the crisis should be handled. They declined to be more

specific.” The difficulty they experienced with their public relations agents extended the crisis stage beyond what it might have been with a more consistent response at the start of the crisis.

One of the biggest failures involved how Jack in the Box and Foodmaker, Inc., handled the franchisees. Several franchisees sued Foodmaker, Inc., for

the losses they suffered after the outbreak. Even by July, the 85 franchisees who operate 325 of the chain’s 450 outlets, claimed losses stemming from sales 30 percent below normal and the failure of Foodmaker, Inc., to adequately compensate “for the financial fallout” following the outbreak (Harrison, 1993). Sellnow and Ulmer (1997) argued that Jack in the Box used strategic ambiguity to “diffuse and confuse responsibility” after the crisis. The result of this strategy was the inability of franchisees to make informed decisions about how to handle their own business practices and their unwillingness to settle financially with Foodmaker, Inc., when the corporation attempted to resolve the matter.

Where Jack in the Box Succeeded

Despite the initial denial of guilt, Foodmaker and Jack in the Box spokespeople presented themselves to the public in a sincere manner that appealed to the general public. Wiley Brooks, a Seattle-based public relations consultant, believed that while Foodmaker “got off to a bad start,” the media were quite critical of the company: “The public never quite bought the media’s edge on the story, mainly because people responded to the sincerity of the television and print ads” (Sims, 1993). The public presence in the media of Robert Nugent, Jack Goodall, and Sheree Zizzi portrayed a company that was taking the matter seriously.

Foodmaker’s strategy to convince patrons that the food poisonings were isolated incidents stemming from a single batch of tainted meat and to offer customers an incentive to return to Jack in the Box proved somewhat successful. The replacement of 28,000 pounds of hamburger with new meat, retraining all employees regarding the handling of meat products, and raising the cooking temperature in Jack in the Box restaurants to the state standard of 155 degrees constituted Foodmaker’s modified public relations strategy. Even though customers tended to order fish or chicken instead of hamburgers immediately following the outbreak (Nogaki, 1993), most customers seemed willing to give Jack in the Box another chance. As Richard Edelman, president of Edelman Public Relations Worldwide in New York, “It’s not the first time that kills your business credibility. It’s the second time” (Nogaki, 1993). By mid-March, business was returning to normal (“Sales rebounding at Jack in the Box,” 1993).

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What Jack in the Box Learned

The corporate management team for Jack in the Box and Foodmaker, Inc., found that denial and deflection were ineffective strategies for managing the E. coli crisis. This was especially the case as the Washington Health Department identified faulty cooking practices that failed to kill the E. coli bacteria present in the tainted meat. The result of inconsistent and conflicting statements was the portrayal of Jack in the Box and Foodmaker, Inc., as self-serving.

The absence of a crisis plan resulted in disagreement over which values should dominate the campaign to regain customers and calm constituent groups within the corporate structure. As corporate leaders gained new insight into how the public perceived the crisis, and new information became available about the contamination of the meat at the slaughterhouse, the decision to expand their response repertoire to include an apology and promises to pay for any damages caused by the crisis was welcomed by the public.

The corporate management team for Jack in the Box and Foodmaker, Inc., found that denial and deflection were ineffective strategies for managing the E. coli crisis.

Implications for Best Practices

Despite being named among the 10 worst United States corporations by Ralph Nader (Reuters, 1993), Jack in the Box restaurants remain throughout the country. While Jack in the Box and its franchisees suffered economically and three people died as a result of the outbreak in 1993, two implications provide insight as other organizations seek to avoid similar crises in the future: (1) Organizations should be open to learning new insights as they confront crises related to their operations, and (2) organizations can avoid conflicting internal strategies when facing similar situations by developing crisis plans.

As Jack in the Box spokespeople confronted the challenge of conflicting information about the cause of the outbreak, the need for organizational learning was apparent. Seeger et al. (2003) suggest that organizations learn by using feedback to “regain stability in light of new information” (p. 38). Drawing from Huber (1996), Seeger et al. distill learning into four processes: “(1) acquisition of knowledge, (2) distribution of information among various sources, (3) interpretation of information, and (4) storing of knowledge for future use, in organizational memory” (2003, p. 38). As early reports of the outbreak were linked to Jack in the Box, the spokespeople had not acquired all of the information they needed to respond. Once more complete information became available, the company leaders were able to interpret what had happened and respond more effectively. When Foodmaker officials finally acknowledged that Jack in the Box could have killed the E. coli bacteria and averted the crisis if food handlers had cooked the meat at the state-recommended temperature of 155 degrees, they had a greater understanding of what would be needed in the future. Clearly, companies can learn from this crisis by developing an organizational culture that is willing “to adapt or evolve in response to their environment” (Seeger et al., 2003, p. 38).

The second implication resulting from this case study is the realization that much of the public backtracking that occurred by Jack in the Box and Foodmaker, Inc., spokespeople could have been avoided had the organization prepared a Crisis Management Plan (CMP) and used it as it dealt with the E. coli outbreak. Drawing from Barton (2001), Seeger et al. describe a CMP as “a strategic document carefully prepared and maintained as a master guide

for framing, overseeing, and tracking a systematic crisis management and response process” (2003, p. 169). Coombs (1999) created a 15-point CMP to assist organizations seeking a more effective way to handle crises. Included in the plan are the following: Names of the crisis management team; contact information for all persons and agencies involved in the plan, including outside groups such as fire, police, hospitals, and regulatory agencies; overview of the types of crises possible; incident report sheets to document what happened, who made decisions, and who was contacted; parameters of proprietary information not to be disclosed without top management approval; a strategy worksheet for constructing messages to the public; secondary and stakeholder contact sheets; a business resumption plan; crisis control center; and details how the CMP will be evaluated (Seeger et al., 2003, p. 170). Had Jack in the Box enacted such a plan and followed its steps, it could have avoided multiple spokespeople presenting conflicting information and might have prevented the continued cooking of meat at unsafe temperatures after the initial outbreak occurred. Rather than shifting blame, all of the information could have been gathered and processed by the crisis management team. Messages to the media and public would have been more accurate and may have appeared less self-serving. The care taken to keep secondary and stakeholders apprised of the situation may have averted the lawsuits that resulted when Jack in the Box spokespeople guaranteed that all claims would be paid to those who had suffered from the crisis. After the crisis past, the plan would have provided the team a means by which the process could be evaluated and improved.

The E. coli outbreak stemming from Jack in the Box restaurants in the Seattle, Washington, area produced a crisis resulting in three deaths, with over 400 people adversely affected. Since the outbreak in 1993, there have been no further E. coli crises associated with Jack in the Box. Through organizational learning and recognizing the need for a crisis management plan to guide how a company responds to such incidents, leaders in business and industry will be better prepared to deal with similar situations in the future.

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Chapter

5

Crisis Plans

and Interagency

Coordination: Lessons

Learned from Tainted

Strawberries in the

School Lunch Program

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Although the American food supply may be the safest in the world, millions of Americans experience food borne illness every year, and some 9,000—mostly the very young and elderly—die as a result (Hingely, 1997). Since 9/11, risks related to bioterrorism have joined the ongoing safety threats to the food system and to the health and well-being of individuals. While foolproof safety systems may be impossible, past experiences demonstrate that planning, preparedness, and interagency coordination not only help prevent crises, but also facilitate prompt response, mitigation, and resolution of crises.

When multiple agencies at many levels are responsible for protecting the health and well-being of school-aged children, prior planning facilitates efficient and effective coordination, and thereby prevents or minimizes significant harm from contaminated foods.

A 1997 Hepatitis A outbreak in the National School Lunch Program provides an opportunity to highlight the vital importance of pre-crisis planning with appropriate stakeholders. When multiple agencies at many levels are responsible for protecting the health and well-being of school-aged children, prior planning facilitates efficient and effective coordination, and thereby prevents or minimizes significant harm

from contaminated foods. Review of this past crisis reveals lessons learned for the optimal development and updating of preparedness and crisis plans.

Case Study Overview

The Governmental Role Industry has primary responsibility for the safety of the food it produces and distributes, but federal, state, and local agencies also work to prevent food borne illness by verifying that industry is carrying out its responsibility and by initiating regulatory control when necessary. Three federal agencies work with industry to prevent food contamination: the U .S. Department of Agriculture (USDA), the Food and Drug Administration (FDA), and the Environmental Protection Agency (EPA) (Fomanek, 2001). The food product determines which regulatory agency has primary jurisdiction.

- USDA: meat, poultry, and egg products.
- FDA: all other foods, including game meats, bottled drinking water, and shell eggs.
- EPA: water, including drinking water from public systems, and the use and disposal of organic and inorganic wastes on agricultural land.

These agencies and the Centers for Diseases Control and Prevention (CDC), the premier U .S. public health agency, respond to outbreaks of food borne illnesses by investigating and managing any failures in the food system (Food and Drug Administration [FDA], 1997).

School Lunch Program

The USDA also regulates foods purchased for and used in federally sponsored food programs. This includes food services in prisons, senior programs, and schools and other institutions. In 1997, over 93,000 schools participated in the National School Lunch Program. Every school day throughout that year, the USDA served over 26 million meals to school-aged children—four billion meals in one year (Food and Nutrition Service, 1997). The USDA purchases only U.S. grown commodities for the school lunch programs, and all suppliers must certify in writing that the product is in fact domestic. In addition to this requirement for vendors, USDA occasionally conducts compliance audits regarding the origin of the product (Knight, 1997).

Interagency Coordination

While each federal agency performs a specific role with defined food products, most outbreaks require coordination between multiple agencies. For example, the FDA is responsible for the safety of processed packaged food, which includes any frozen strawberries or products made from the strawberries. The USDA, however, shares responsibility for the same product when it is purchased and used in federally-sponsored food programs. The CDC provides the epidemiologic and public health expertise to determine the cause of outbreaks and to recommend treatment options for the health of affected and vulnerable persons. In the event of an outbreak from food served in the National School Lunch Program, the FDA, the USDA, and the CDC all assume investigative and management responsibilities (FDA, 1997). State and local agencies maintain interagency coordination with their federal counterparts and with agencies serving the same geographical area.

Contaminated Strawberries—Hepatitis A Outbreak

In March 1997, over 200 children and teachers in Michigan became sick with Hepatitis A as a result of eating contaminated strawberries as part of their school lunch. Although the Hepatitis A outbreak occurred in Michigan, government agencies quarantined millions of pounds of frozen strawberries in 15 states and the District of Columbia. Additionally, school officials in several states ordered thousands of children who had consumed strawberries linked to the contaminated shipments to be protectively vaccinated (Hong, 1997).

Crisis Timeline

Pre-Crisis Phase

- Strawberries grown and harvested near San Quentin and Baja California Norte areas in Mexico, then sold and transported to Andrew and Williamson Sales, Inc., (A&W) in San Diego, California. One week after the confirmed Hepatitis A outbreak in Michigan, FDA investigators found the fields where the strawberries originated contaminated (McClain, 1997), with open-pit latrines and no hand-washing facilities or health procedures in place (Knight, 1997).
- A&W intentionally mislabeled Mexican-grown strawberries as 100% U.S. grown. The strawberries sold to vendors for the USDA School Lunch Program.

Crisis Phase

- Over 200 children and adults contracted Hepatitis A in Michigan.
- Michigan state authorities informed the CDC of possible Hepatitis A outbreak in multiple schools in two different counties.
- CDC, USDA, and FDA linked Hepatitis A outbreak to contaminated strawberries.
- USDA and FDA notified states of possible contamination in other shipments of strawberries and suspended further serving in schools.
- FDA began investigation of A&W.
- Schools coordinated the administration of gamma globulin for any persons consuming potentially contaminated strawberries and within the time period of vaccine effectiveness.

Post-Crisis Phase

- A& W indicted for fraud.
- A&W convicted and required to pay \$1.5 million.

Theoretical Underpinnings

Crisis plans are the most critical tool for crisis prevention and resolution, especially when multiple agencies must coordinate their efforts. Crisis planning begins with the projection of possible crises and the identification

Crisis plans are the most critical tool for crisis prevention and resolution, especially when multiple agencies must coordinate their efforts.

of the stakeholders, structures, resources, and strategies “necessary to resolve the crisis with as little disruption, cost, and harm as possible” (Seeger, Sellnow, and Ulmer, 2003, p. 163). In the event of a crisis, prior planning positions agencies to

respond and recover without delay or exclusion of important partner agencies. As systems theory illustrates, when failure in one part of the system occurs, the consequences and repercussions due to failure will impact may other parts (Seeger et al.). Advance planning better situates agencies to effectively manage crises through the creation of “a set of anticipatory measures that enables an organization to coordinate and control its response to an emergency” (Nudell and Antokol, 1988, p.21).

When crises in food safety occur, communication plays a pivotal role. Crisis response and mitigation requires uncertainty reduction, coordination, information dissemination, and messages relevant to the specific needs of each stakeholder (Seeger et al., 2003). Agencies at multiple levels work to determine the nature and magnitude of the outbreak, to assess the multidimensional impact and potential consequences, to provide accurate and reliable information, and to make informed and acceptable decisions with the participation of all stakeholders. Stakeholders include interested parties likely to be affected by any system failure or crisis. Contact and working relationships prior to crises best ensures timely contacts, dialogue, and responses during crises. During the stress and uncertainty of a crisis, it is easy to overlook important stakeholders. However, failure to communicate effectively with all stakeholders can actually increase outrage and harm by denying stakeholders the information they need to make informed decisions or by excluding stakeholders that disproportionately bear the consequences of a crisis from participation in crisis management.

Method

This analysis employed a case study method to develop descriptions of how the events, coordination processes, and external communication pertaining to a 1997 Hepatitis A outbreak in the Michigan school lunch program were portrayed in media coverage. Specifically, newsprint reports about interagency and stakeholder coordination indicated the importance of planning and preparedness when responding to a food borne illness outbreak that involves national, state, and local entities.

The data for this study included national and local coverage by major print media sources for the six months following the outbreak in March 1997. Articles were obtained through *ProQuest Newspapers* and *LexisNexis* databases. Key events in the case and themes of communication are described from the perspectives of crisis communication and crisis planning.

Analysis

In December 1996, the USDA approved a contract with Andrew and Williamson Company Sales, Inc., (A&W) in San Diego, California, for the purchase of strawberries. The contract specified that the processed frozen fruit had to originate from crops 100% grown, processed, and packed in the United States and required A&W to supply a written statement certifying that the products delivered to USDA met such specifications. A false statement to federal officials concerning the origin of a product is a criminal offense, punishable by up to five years in prison and significant fines (Krikorian, Ramos, and Groves, 1997). Civil penalties may be assessed, including debarment from federal contracting and the loss of a license to sell perishable agricultural commodities. A&W provided the required certifications directly to the USDA and through three brokers. Although USDA officials conduct random inspections at packing plants with which they have a contract, no federal official had inspected A&W since 1988 (Knight, 1997).

As subsequent investigations revealed, during the winter of 1996 A&W had purchased strawberries grown on remote ranch properties near San Quentin and Baja California Norte in Mexico. A&W processed, packed, and froze the purchased strawberries in 30-pound containers for commercial use and distributed about 900,000 pounds of the strawberries to commercial outlets, which used the fruit for making dessert toppings, pies, and cocktail mixes. A&W later distributed 1.7 million pounds of frozen strawberries to the USDA through four vendors: Kendall Frozen Fruits, Inc., of Encino, California; Pacwest Foods, Inc., of Newbury Park, California; JSO Associates, Inc., of Great Neck, New York; and New West Foods of Watsonville, California. They provided the required certification, "100% U.S. grown," directly to the USDA and the four vendors. Wawona Farms in Clovis, California, packed the strawberries in cups in early 1997 and shipped the frozen dessert cups to schools ("Holes cannot," 1997). These shipments contained strawberries later associated with the Hepatitis A outbreak.

The USDA had received reports early in 1997 that a San Diego firm was illegally purchasing foreign-grown strawberries for use in school lunches but failed to act before the Michigan Hepatitis A outbreak occurred (Knight 1997). According to Kenneth Clayton, deputy administrator of Agricultural Marketing Services, one reason the reports were not acted upon was that competing packing plants sometimes spread unfounded rumors about one another (Knight).

The Michigan Department of Health notified the CDC of a possible Hepatitis A outbreak in schools of two counties on 24 March 1997 (Walsh, 1997). Public health authorities invited an epidemiologist from CDC to investigate, and on 27 March, the Michigan Department of Health in collaboration with the CDC informed the FDA and USDA of the outbreak and its possible link to frozen strawberries served in school lunch programs. FDA officials contacted A&W in California, beginning an investigation of the facility and its production and distribution records. USDA officials instructed states that may have received the possibly implicated product to suspend the use and distribution of frozen strawberries in the school system until further notice (Allen, 1997). Among these states were six—Michigan, Arizona, southern California, Georgia, Iowa, and Tennessee—known to have received the implicated product (Walsh, 1997). As an additional precautionary measure, the USDA informed ten other states—Florida, Illinois, Indiana, Maine, New Jersey, New York, North Carolina, North Dakota, Washington, D.C., and Wisconsin—not to use strawberries from the California-based company until more information was available (Miller, 1997).

USDA's Food, Nutrition, and Consumer Services worked with states to notify and advise individual school districts and schools.

On 28 March, in the late afternoon, the CDC concluded that the outbreak was associated with frozen strawberries served in school lunch programs (Krikorian et al., 1997). The next day, 29 March, the CDC notified state epidemiologists in states that had received the strawberries and asked them to work with school officials to identify any students that might benefit from gamma globulin. Public health officials shipped doses of gamma globulin to areas where the berries were served. Schools in coordination with local public health departments initiated mass inoculations; thousands of children in six states potentially benefited (Hong, 1997). As later mandated, A&W would pay for the \$18-per-dose inoculations of gamma globulin (Levin, 1997).

Although the Los Angeles school district received fax notification on Thursday of the possible contamination and the need to suspend use, strawberry dessert cups were still served on Friday in twelve elementary, two middle, and three high schools (Krikorian et al., 1997). After some delay, food service personnel received the notification. One school, however, served the desserts on Monday after failing to receive the notification Friday. "A clerical error left Mount Vernon off," a school district spokesperson explained. "By the time we contacted the food service manager, the fruit cups had already been served" (Altman, 1997). Southern California officials announced on Tuesday, 1 April, that within the past week some 9,000 school children and school employees in the Los Angeles School District had been served frozen strawberries from the implicated lots and could be at risk of contracting Hepatitis A (Allen, 1997; Chung and Marquis, 1997; "Holes cannot," 1997).

Although school officials were notified on Thursday, parents and the public were not informed about the potential contamination until Tuesday (Chung and Marquis, 1997; Holes cannot, 1997). School officials said "they wanted to confer with the county public health department over the best method of notifying parents" (Krikorian et al., 1997). The USDA's inspector general continued to investigate why A&W intentionally and illegally mislabeled and sold the Mexican berries as domestic. Epitope, Inc., of Beaverton, Oregon, A&W's parent company, confirmed in a statement that A&W inaccurately described the strawberries associated with the outbreak as having been grown and processed in the U.S. "We have notified the USDA of our concern with regard to this matter and have today accepted the resignation of Fred L. Williamson, president and CEO of A&W," said Epitope president Adolph I. Ferro (McKenna, 1997; Walsh, 1997). Only days later, Epitope said it sued Andrew and Williamson to try to rescind its recent purchase of this company on the grounds that the company had failed to disclose that strawberries, grown in Mexico, had been mislabeled as U.S.-grown produce (Effinger, 1997).

Meanwhile, FDA officials found that containers of A&W strawberries had spread far beyond school cafeterias and were still available to consumers in Michigan. Officials found berries at distributors, restaurants, and retailers in the Detroit area. Caramagno Foods Company of Detroit had received berries from 17 May 1996, to 31 December 1996 (Siemaszko, 1997). Commercial processors used them in jams, jellies, pies, and even daiquiri mixes. However, since such products require high levels of heat during processing, spread of the virus through these products was unlikely. Also, because of the distribution dates, most of the strawberries likely had been consumed some time before the outbreak (Siemaszko). Agway, an agricultural cooperative in Syracuse, New York, said it was voluntarily recalling 779 containers of frozen strawberries from its stores after learning they came from A&W. The Syracuse-based cooperative

said the recall was precautionary and was not requested by regulators (Levin, 1997).

Mexican growers, who depended on a \$1.9 billion-a-year export business, feared losing U.S. markets due to the Hepatitis A outbreak link to strawberries grown in Mexico. At the same time, Californian growers feared a negative industry impact. California's Secretary of Agriculture, Ann Veneman; Secretary of Health and Welfare Sandra Smoley; and lawmakers from strawberry-growing districts publicly assured the general public in a news conference that the state's \$552 million-a-year crop was safe (Claiborne, 1997; Levin, 1997).

On 25 April, the USDA announced that A&W and its former president, Frederick Williamson, falsely certified the strawberries as "100% grown and packed in the United States." A&W was suspended from contracting until the government's investigation and any related legal actions were completed ("USDA suspends," 1997;

Numerous agencies and stakeholders throughout the country coordinated measures to prevent and to mitigate the consequences of a food borne illness.

Kraul, 1997). A San Diego federal grand jury indicted A&W and its president on 11 June. The 47-count indictment included one count of conspiracy to defraud the government, three counts of making false statements, and 43 counts of false claim ("Indictments issued," 1997). The charges related to the sale of 1.7 million pounds of Mexican-grown strawberries for more than \$902,000 to the USDA's school lunch program (Claiborne, 1997). Each charge carried a maximum penalty of five years in prison and a \$250,000 fine (Claiborne, *LA Times* and *Washington Post Services*, 1997). The maximum fine against the corporation on each count was \$500,000.

The indictment alleged that Williamson and A&W used three food brokers in California and New York to disguise the fact that the strawberries were not grown domestically. In addition, the company "attempted to conceal the true origin" of the shipments by submitting false certificates of the strawberries' origin. A&W's strawberry salesman Richard Kershaw plead guilty to charges related to the incident and cooperated with the government; however, the company denied the charges. "We believe the charges filed today in federal court are mistaken and will be shown to be wrong," a company statement read ("Indictments issued," 1997).

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In May, Epitope and A&W agreed to rescind their purchase deal (Claiborne, *LA Times* and *Washington Post Services*, 1997). Epitope said the former owners of A&W agreed to take back their company and return the 520,000 shares of Epitope stock they had accepted as payment (Woodward, 1997). Epitope also left behind the potential liability for the Hepatitis A outbreak and, at the time, two class-action suits in California and Oregon. By late May/early June, potentially exposed individuals had likely reached the end of any hepatitis incubation time period.

The Hepatitis A outbreak affected 213 children and teachers in Michigan

and led the government to quarantine millions of pounds of frozen strawberries in 15 states and the District of Columbia (Hutin et al., 1999). School officials in several states ordered thousands of children who had consumed strawberries linked to the contaminated shipments to be protectively vaccinated (Claiborne, LA Times & Washington Post Services, 1997). Numerous agencies and stakeholders throughout the country coordinated measures to prevent and to mitigate the consequences of a food borne illness.

On 14 November, A&W pleaded guilty to fraud and to selling 1.7 million pounds of Mexican strawberries. The firm agreed to pay the federal government \$1.5 million. A&W was banned for several years from selling strawberries to the USDA school lunch program.

The multi-state, multi-agency coordination be-speaks of efficient and effective mobilization for the prevention or resolution of food borne illness outbreaks.

Conclusions

As the description of events highlights, multiple agencies at the federal, state, and local level became involved as a result of the Hepatitis A outbreak. Analysis of the outbreak and subsequent action to minimize the number of cases indicates that coordination efforts succeeded better at the national and state level than at the local level. Additionally, direct participation of parents, primary stakeholders, was delayed and minimized.

Where they succeeded

The CDC swiftly notified the USDA and the FDA of the possible link to strawberries, which resulted in coordinated yet separate investigative efforts. The CDC continued to verify the cause, the FDA investigated the product and its possible origin, and the USDA acted to suspend the further distribution and use of the suspect product in federal food service programs, all happened within a couple of days. Soon thereafter, the CDC informed state epidemiologists who in turn worked with local health departments and school districts to inoculate any individuals who could benefit from gamma globulin inoculation. The multi-state, multi-agency coordination bespeaks of efficient and effective mobilization for the prevention or resolution of food borne illness outbreaks.

Where they failed

Time-sensitive alerts require an expedient and coordinated routing procedure. The short delay and the internal fax routing resulted in the unnecessary exposure of approximately 9,000 individuals in Southern California. The Los Angeles school district's minimal yet significant delay reveals an organizational risk preparedness weakness in supportive services. When informed of the potential exposure to Hepatitis A, the school district delayed notification to parents until they could develop a game plan ("Holes cannot," 1997). While this decision did not increase the risk of contracting Hepatitis A, since incubation period of Hepatitis A is approximately one month, the decision did foster outrage among parents (stakeholders) when they became aware of the deliberate delay in notification (Krikorian et al., 1997). This potentially undermined trust between parents and the school district and diminished the perceived credibility of the school officials.

What they learned

Crisis plans must identify, or develop, and result in the use of pre-established routing procedures for the dissemination of information between

agencies. The local experience in the Los Angeles school district demonstrated the consequences due to delays in information routing. Moreover, school districts are well advised to inform parents of potential risk as they become known. The Southern California school district could have shared the information, including the window of time to make decisions, and shared the process for making decisions about inoculations.

Implications for Best Practices

When interagency coordination in food safety issues is required, planning is the most important crisis management activity those involved can undertake (Seeger et al., 2003). Unfortunately, planning for specific food-related crises often takes place only after a tragedy, as was the case of the Hepatitis A outbreak in 1997, when the Southern California school district had not planned sufficiently for possible crises. This type of failure points to the need for every organization involved to review and update their food-related crisis plans to ensure that the inter- and intra-agency efforts will be well coordinated. Local agencies also need to focus on the public as a stakeholder with the right to timely information and to participation in the decision-making process. Each organization or institution should develop crisis plans that include how potential food-related crises will be managed. Among the components of the crisis plan should be the procedures for distributing, receiving, and handling health-related alerts and procedures for contacting and communicating with identified stakeholders.

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**Chapter
6**

**Monsanto's Genetically
Engineered Wheat
Crisis:
Lessons Learned
from Faulty Diffusion
Strategies**

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Monsanto Chemical Works of St. Louis, Missouri, was founded in 1901 by John Queeny and named for his wife, Olga Monsanto. The company's first commercially successful product was saccharin, followed shortly thereafter by refined caffeine, vanilla, and aspirin. Within thirty years, the company had expanded its business and product portfolio to include a number of manufacturing facilities in both the U.S. and abroad. In 1933 it was renamed "Monsanto Chemical Company" (*Monsanto Historic Archive*, 2004).

In the early 1980s, the all-encompassing term, "Bio-Technology," was eagerly

Today, Monsanto is a multinational corporation with several thousand employees worldwide and continues to be the leader in genetic engineering (GE) and genetically modified (GM) foods and the number one supplier of GMO seeds and food biotechnology.

embraced by Monsanto to describe its research activities and subsequent manufacturing advances in the plant and animal sciences for the purpose of increasing food production and developing pharmaceutical products. Today, Monsanto is a multinational corporation with several thousand employees worldwide and continues to be the leader in genetic engineering

(GE) and genetically modified (GM) foods and the number one supplier of GMO seeds and food biotechnology.

Genetic engineering refers specifically to technologies involving recombinant deoxyribonucleic acid (DNA) wherein a single gene from one organism is placed into another, with the resulting organism considered genetically modified. An organism so modified, or transformed, is commonly referred to as a genetically modified organism (Janzen, Mattson & Wilson, 2001). As GE application in crop varieties become more prevalent, marketing channel participants face new opportunities, challenges, and risks associated with the development, use, and handling of the resultant products (Van Wechel et al., 2003).

There are numerous risks associated with the adoption and production of GM wheat. Arguments being made against GE wheat included opposition to GE wheat from major wheat markets, impossibility of segregating GE from non-GE wheat after commercial approval, significant agronomic problems associated with GE wheat and commensurate increases in costs for farmers, threats to organic farming, unresolved liability issues arising from farmers who face genetic contamination or market loss, and environmental and possible human health risks from GE wheat.

From its inception, GM foods, in Europe commonly referred to as "Frankenfoods," (Silk, Parrott & Dillow, 2003), have raised political, societal, and emotional issues. According to Mayon-White (2003), there is a global fear that its producers and government agencies will be unable to protect the public from GM foods, which are generally considered unsafe. One of the reasons for the distrust is that scientific risk assessments do not convince many people who make value-based judgments on the safety of consumer products (Mayon-White, 2003). Another is the question, "How safe are GM foods?" The answer to this question has a political dimension that cannot be ignored but it is not the focus of this paper.

According to Nestle (2003), some of the questions that followed the introduction of GM crops are: What are the risks GM foods? What are their benefits? How are risks and benefits distributed? Who makes decisions about them? How will GM foods affect local, national, and international food systems and economies? How should the foods be regulated? Should they be labeled? And is it ethical to create such foods in the first place?

What was disturbing in the public’s mind was the fact that Monsanto, knowing the global fear and outrage concerning GM products, did not address some of these questions before introducing its GE wheat. Although coping with a product innovation is usually a challenge for a company, but to be successful new products must be properly diffused by their innovators.

In 30 July 2002, Monsanto pulled back its stated 2005 timeline for bringing the first genetically modified wheat (GE Wheat) to market. The company was not acknowledging that the crop would be delayed, but no longer stated a timetable, saying only that it would bring the crop to market after it met certain goals, such as building demands for the product and devising a system for segregating GE wheat from other wheat (Delay is seen... 2002). The new position reflected the difficulty the company was having in winning acceptance for the crop. Wheat millers in Japan, Canada, and Europe—large markets for American wheat—said they did not want genetically-modified products (GMOs). And some American farmers feared that GE wheat would be mixed with other wheat, hurting exports in general. Moreover, many countries are reluctant to embrace GE foods (Gillis, 2004).

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Research Question

To what extent did Monsanto succeed in its GE diffusion strategies, especially with its main stakeholders?

Database

Database for this research was drawn from online newspapers articles and Monsanto annual reports, online Monsanto-sponsored biotechnology research reports, and online GMOs studies conducted by other institutions. The online newspapers articles came from two main databases: *Proquest Newspapers* and *NewsBank Info Web (America’s Newspapers)*. The search was limited to newspaper articles dealing with the Monsanto GE wheat story.

Crisis Timeline

Pre-crisis Phase

- 27 February 2001 Monsanto’s gene-spliced wheat stirs global fears of GE wheat.
- 24 March 2001 North Dakota weighs 2-year ban on biotech; Monsanto put up a stiff fight.
- 31 July 2002 Monsanto pulls back from its stated 2005 timeline for marketing it wheat.
- 22 December 2002 Farmers’ worries about GE wheat continue as U.S. consumers reject it.
- 4 October 4 2003 Monsanto ignores Canadian wheat board protest against GM wheat.

Crisis Phase

- 7 April 2003 Demonstrators rally outside the offices of Monsanto Canada Inc. to protest open-air trials of GE wheat.

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| 1 May 2003 | Monsanto faces further loses from Roundup sales. |
| 31 May 2003 | Global resistance to GM foods is destroying Monsanto but the company aggressively makes moves to get its GE wheat approved for consumption. |
| 22 November 2003 | The USDA assures foreign buyers that no GE wheat will be on market. |
| 8 January 2004 | Monsanto reports a wider net loss for its fiscal quarter. AgCan ends and abandons testing of GE wheat developed by Monsanto. |
| 10 January 2004 | Canada's Organic Farmers tell Monsanto to drop GE wheat project. |
| 27 January 2004 | Monsanto seeks support for GE wheat or it might abandon its research. |
| 3 March 2004 | Monsanto forces U.S. approval of GE wheat even if Canada says no. |
| 19 March 2004 | Japan, largest consumer and buyer, says no GE wheat or they will stop buying. |
| 27 March 2004 | Japanese coalition presents petitions signed against GE wheat. |

Post-crisis Phase

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| 11 May 2004 | Monsanto pulls plan to commercialize GE wheat. Monsanto abandons worldwide GE wheat project:a victory for protesters. |
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Theoretical Underpinnings

Diffusion Theory

Diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system (Rogers, 1995); whereas an innovation is an idea, practice, or object perceived as new by an individual or other unit of adoption (Rogers & Singhal, 1996). The diffusion process involves both mass media and interpersonal communication. Thus, diffusion is a special type of communication in which the message content is concerned with a new idea. Although the newness of an idea gives diffusion its special character, it also indicates that some degree of uncertainty is involved which can only be reduced through information flow. Diffusion refers to the spread of something within a social system and it should be taken as far as one's constructionism permits to denote flow from a source to an adopter. Furthermore, when new ideas are invented, diffused, and adopted or rejected, leading to certain consequences, social change occurs.

In his comprehensive review and general framework of diffusion, Rogers (1995) singled out four main elements of diffusion: innovation, communication channels, time, and the social system, which are identifiable in most diffusion studies, campaigns, and programs. Each one of these elements has its characteristics, but time is the most crucial ingredient in the diffusion process because it enables the researcher to identify the characteristics of early-adopters and to establish the direction of the flow of influence (Katz et al., 1963). The time dimension in diffusion also involves the innovation-decision process of knowledge, persuasion, decision, implementation, and confirmation,

by which an individual passes from first knowledge of an innovation through its adoption or rejection; the innovativeness, i.e, the earliness/lateness with which an innovation is adopted; and the rate an innovation is adopted in a system (Rogers, 1995).

In addition to the four main elements, Rogers (1995) further explains the six main phases in the innovation-development process. First, a need or problem is recognized. This stimulates the research and develop activities necessary to solve the problem or to fill need. This results in the development of an innovation, which is essentially the process of putting a new idea in a form that is expected to meet the need or to solve the problem. Commercialization—the production, packaging, and marketing of the product—follows, leading to the consequences of an innovation, the change that occurs in a social system as result of the adoption or rejection of the innovation.

Monsanto's early-adopters (farmers) rejected the GE wheat innovation, organizing boycotts before the GE wheat was commercialized and making it impossible for the company to be able to honor its 2005 timeline.

Monsanto's early-adopters (farmers) rejected the GE wheat innovation, organizing boycotts before the GE wheat was commercialized and making it impossible for the company to be able to honor its 2005 timeline. The question worth asking here is why, given the global fear of GMOs, Monsanto introduced its GE wheat before determining whether or not there was a felt need for any new genetically engineered product.

Analysis

Pre-crisis Phase

Prior to the introduction of GE wheat, Monsanto failed to determine whether or not there was a need for the innovation. As a result, Monsanto faced a commercialization crisis when the introduction of GE wheat generated numerous protests and rejections from Japan, Europe, and Canada, its main markets. According to Nganje and Wilson (2004), when developing the product Monsanto placed an emphasis on producer gains, the first stage benefits, and gave little consideration to consumer interests, the phase two benefits. From the beginning, Monsanto knew that GE wheat production cost of would be lower, but higher productivity would mean more profit for the company.

In giving little consideration to phase two benefits of GE wheat production, Monsanto failed to determine whether or not the public felt any need for such an innovation, carrying out research and introducing its new GE product without any prior consumers research. By failing to create a need for the new product and instigating research where there was no problem/need to be solved, their innovation created problems, which led to the crisis.

Furthermore, prior to the adoption of GM varieties, it was common simply to sell on grade and non-grade factors. National and international buyers now require varying types of information on GM varieties and agronomic information on production practices (Nganje & Wilson, 2004). As a result, information requirements and health risk awareness for GM foods have become more critical. However, when introducing the new GE wheat, Monsanto did not sufficiently inform its stakeholders about its risks and benefits, especially as consumers' perception of GM foods was changing (Martin, 2004). Because GE crops do not have a direct consumers benefit, but rather are designed to help farmers, these crops can be seen as posing a potential and unknown risk

(Schubert, 2002).

In developing its GE crop varieties, Monsanto had three main stakeholders: farmers, producers, and consumers. However, the company's strategy for years has focused only on farmers because they provide direct income to Monsanto (Monsanto could be another. . . , 2003). The implication is that the company's product development strategy discounts the importance of consumers and food producers. By failing to include consumers and food producers its overall

business model, Monsanto failed to realize that an effective stakeholders relationship involves balancing the competing needs of various stakeholders and communicating openly, honestly, and frequently with them (Ulmer & Sellnow, 2000).

Thus, market rejection of Monsanto's previous GE crops in one segment of the economy also influenced the market rejection of GE wheat in other segments.

Furthermore, the commercial products of food biotechnology have

caused no end of controversy. Because of consumer and farmer concerns about GM crop safety, Monsanto has failed for the past six years to get GM crops approved for import or cultivation in Europe. In the U.S., Canada, Asia, and Europe, particularly Great Britain and France, people view GM foods with suspicion, often with dread and outrage. The results of such dread and outrage are boycotts, destructions of plantings, legal bans, and trade disputes. Such reactions reflect misgivings about the risks of technological manipulations of foods, not only to human health, but also to the environment, to the world economy, and to society as a whole (Nestle, 2003). They also reflect public distrust in Monsanto's GE research activities, which are seen as designed primarily to create more benefits for the company. Consequently, numerous ethical concerns, including safety, scientific hubris, and disclosure, created a sense of unease resulting in worldwide rejection of GE wheat.

In the process of developing GE wheat Monsanto encountered two major problems: lack of consumer market acceptance and risk exposure stemming from possible genetic contamination of food crops (Monsanto could be another. . . , 2003). These comprised the main risks to its stakeholders. Thus, market rejection of Monsanto's previous GE crops in one segment of the economy also influenced the market rejection of GE wheat in other segments. For example, general consumer rejection of GE foods led food producers to abandon GE foods. Similarly, farmers in North America questioned the commercialization of GE wheat due to the potential loss of lucrative markets, globally, and not just in Europe.

In the face of this rejection, many farmers and officials worried that GE wheat, not yet on the market, could harm producers because some U.S. export customers did not want it. Some farmers also worried that trial plots could contaminate fields of traditionally grown wheat or organic grain. In 2001 North Dakota lawmakers rejected a two-year ban on GE wheat seed proposed by Greenpeace activists in 30 European cities and organic farmers in Canada and called instead for a study of biotechnology issues (Brasher, 2001). This was the crisis-triggering event.

Crisis Phase

Monsanto started field-testing its GM wheat in 1997. In 2002, it applied to commercially grow the GM wheat, modified to resist the company's own herbicide, Roundup Ready, in the U.S. and Canada. The mainstream farming community, non-governmental organizations, industrial wheat sellers,

processors, and users; however, all asserted their opposition to the commercial introduction of GE wheat. While some of these parties have traditionally supported the use of GE crops, few supported the introduction of Monsanto's GE wheat.

As news of Monsanto's GE wheat spread, buyers from Japan to Europe and Canada told U.S. exporters that their consumers would not accept GE wheat because of general fears about possible harm to the environment and health risks from GE crops. Some said the wheat's very presence on American farms could threaten future purchases of all U.S. wheat, since more than half of American wheat is exported, accounting for \$3.7 billion in sales and almost 20% of all agricultural products shipped abroad in 1999 (Genetically engineered wheat, 2003). Numerous protests and resistance to the commercialization of GE wheat from it Japan, Europe and Canada, the main markets, triggered the crisis.

Lack of complete knowledge of GE wheat risks was a problem for investors and farmers. For example, buyers wanted information about traits under development, approved traits, and where the product is geographically concentrated (Wilson et al., 2003). But prior to its development, the company ignored its stakeholders' demands for information about the new product. This led to the lack of market acceptance as Monsanto's early adopters questioned the credibility of the latter's decision to diffuse a new product with no specific benefits for them.

Rejection of the new product created an economic disaster for agricultural industries and for Monsanto, which had invested heavily in the new crop (Gillam, 2004). Moreover, the fact that farmers, Monsanto's direct constituents, organized boycotts against GE wheat before it was commercialized meant the company would not be able to keep to its 2005 timeline. Similarly, farmers in North America, seeing the potential loss of lucrative markets in Europe, but also in Asia, Canada, and Egypt, questioned the commercialization of GE wheat.

The economic record of Monsanto's investment in the development of GE wheat remains unclear and GE crops have been a mixed bag for developers and farmers. While Monsanto lost \$1.7 billion in 2002 due to droughts and growing competition for its Roundup herbicide for GE wheat, the financial benefits for farmers were also unclear, with studies showing both negative and positive financial results and risks in the investment of GE wheat (Monsanto could be another..., 2003). The company said it spent \$5 million annually on research to develop GE wheat, barely 1% of its research budget, yet it was still a major financial blow.

In its 2002 Annual Report, Monsanto addressed what many financial observers considered the company's most pressing issue: the loss of its patent on its Roundup glyphosate herbicide for its GE wheat. Company representatives estimated that its market share would likely drop from 77% currently, to the low 60's by around 2005. This drop, combined with increasing market rejection for GE wheat, had a negative effect on the company's profitability (*Monsanto Historic Archive*, 2004).

In addition, the effects for Monsanto of Roundup competition for have been considerable, with an estimated \$1.69 billion in lost revenues, and a 14% drop in overall revenues from 2001. In some cases, Monsanto had been driven out of the glyphosate market altogether, as was the case in Australia, where competition from cheap Chinese imports caused the company to close its manufacturing plant there (ACCC accepts undertakings, 2002). Based on Monsanto's estimates, losses in the glyphosate business to prevent the spread

of GE wheat into a superweed could be anywhere in the \$400 to \$500 million range by 2005, representing roughly between \$1.50 and \$1.90 per share at current levels of market capitalization (*Monsanto Historic Archive, 2004*).

Faced with global opposition to the commercialization of its new product, Monsanto pushed back the proposed introduction of its GE wheat from 2003 to 2005, and the company stated that it would only do so then if it could first gain pre-acceptance from buyers, as well as environmental and health clearance from regulatory authorities (*Monsanto Historic Archive, 2004*). A spokesman for Monsanto, Mark Buckingham, said the company was planning to file for regulatory approval of GE wheat, but that Monsanto would not introduce the product until it had “industry acceptance across the board,” which will take more time (Delay is seen, 2002).

As the issue gained urgency the company told industry leaders they must fully embrace the project and

help gain market acceptance or Monsanto would be forced to abandon GE wheat research after investing millions of dollars in the project (Japanese consumers tell Canada. . . , 2004). As no market acceptance was gained for the new GE crop because of consumer resistance, Monsanto was forced to modify plans to commercialize the crop. The company said it would cut most of the \$5 million it spends annually to develop the crop (Gillis, 2004). But the question here is whether Monsanto acted in good faith when it announced that it planned to realign research and defer all further efforts to develop and commercialize GE wheat until new biotechnology traits are introduced.

Post-Crisis Phase

The strong rejection of GE wheat from virtually every corner of the globe once again showed the resistance to GE foods. Due to this stiff opposition, on 10 May 2004, Monsanto abandoned plans to introduce GM wheat on the world market (Kilman, 2004). After a long struggle to impose on its stakeholders, Monsanto finally acknowledged very late that there was no consumer need or problem that necessitated research and development of a new GE crop. Thus, its decision to abandon the GE wheat was a major victory for the anti-GMO lobby, and it followed pressure from U.S. and Canadian farmers who feared that the introduction of GM wheat would lead to the collapse of their billion-dollar markets in Europe and Japan (Brown, 2004).

Monsanto’s efforts to develop GE wheat had been watched around the world as a bellwether for the future of agriculture, and its decision to drop the innovation, although a victory for consumers and farmers, was a bitter defeat for the company. According to Joseph Mendelson, III, legal director of the Center for Food Safety, “When you get farmers and consumers aligned about what the marketplace really wants, Monsanto doesn’t stand a chance” (Martin, 2004). Others suggested, “it marks the beginning of the end of genetically engineered crops as a major force in global agriculture” (Monsanto drops plans. . . , 2004).

Conclusions

Where they Failed

- Little consideration was given to consumer benefits, the phase two benefits, when developing the product. As a result, Monsanto failed

As no market acceptance was gained for the new GE crop because of consumer resistance, Monsanto was forced to modify plans to commercialize the crop.

to create a need for its innovation.

- Monsanto reneged on its commitment to delay the introduction of GE wheat and pressured US wheat growers to support a U.S.-only introduction.
- Monsanto kept shifting its timeline for the commercialization of GE wheat and mounted pressure for U.S. approval despite initial rejections.
- Collective boycotts and global outcries against GMOs created the need for alternative measures, e.g., labeling, but Monsanto wanted either no labels or simple labels suggesting only that the product might contain GMOs.
- The direct actions and boycotts brought global attention to the uncertainty of GMO technology and raised public demands for GMO labeling .

There is no doubt that global resistance to “frankenfoods” (Alexander, 2003) is affecting Monsanto, but the company can use the GE wheat crisis as an opportunity to acquire new information, skills, insights, and capabilities on how to diffuse subsequent innovations.

Where they Succeeded

- Monsanto publicly committed to delaying the introduction of GE wheat and changed its stated timeline in an attempt to gain market acceptance.
- As the issue gained urgency, Monsanto told industry leaders they must fully embrace the project and help gain market acceptance or the company would be forced to abandon research on GE wheat.
- Monsanto announced on 10 May 2004, that was abandoning research and development of GE wheat, calling it “realigning research and development investments.” A victory for consumers and farmers.

What they learned

- Recognition of a need or a problem should precede research, development, commercialization and diffusion of an innovation.
- Establishing effective communication relationships with stakeholders well before crises erupt is beneficial for organizations during crises.
- Consumers (adopters) have the right to reject any innovations they do not want.

Implications for Best Practices

Failure is an essential prerequisite for effective organizational learning and adaptation (Sitkin, 1996). According to Seeger et al. (1998, 2003), crises are part of the natural organizational process, purging elements of systems that are outdated and inappropriate and creating new, unexpected opportunities for growth and change. Monsanto should have learned that genetic engineering, especially GE wheat, has proven controversial internationally because there is no need for its innovation. GE products have been banned in many countries because of fears that they may not be good for people and the environment.

There is no doubt that global resistance to “frankenfoods” (Alexander, 2003) is affecting Monsanto, but the company can use the GE wheat crisis as an opportunity to acquire new information, skills, insights, and capabilities on how to diffuse subsequent innovations. Lack of emphasis on consumers’ benefits, failure to provide information on the environmental and health risks of GE wheat, and the absence of an original need ultimately resulted in global fear and outrage leading to product rejection (Bueckert, 2004).

Monsanto's arguments for its innovation failed to target the core concerns of its stakeholders. The company failed to address key issues such as lack of farmers' awareness of differences between GE crop varieties and other crops, lack of information provided to farmers stating they were buying GE seeds, lack of awareness of market rejection by consumers, and environmental problems associated with GE wheat. Instead of targeting these core concerns, Monsanto framed GMOs rejection as "trade barriers" by competing governments. It also ignored GE crop contamination of neighboring farms, which led to infringement cases and lawsuits against farmers (Monsanto could be another. . . , 2003).

According to Seeger et al. (2003), crisis events represent a chance for an organization to acquire new information, skills, insights, and capabilities; therefore, organizations that are able to learn have the potential to emerge from crises with a renewed sense of purpose. This implies that Monsanto can use the GE wheat crisis as a significant opportunity for learning and to restore its image and research on GMOs. The company's decision to abandon development of GE wheat is a good start in its learning process, but it needs to go further, making consequential changes in order to emerge from the crisis with a renewed sense of purpose.

Crises have the potential to disrupt organizations, but if managed effectively, can also be an opportunity to create new knowledge and change. For instance, the fires at Malden Mills and Cole Hardwoods gave these companies opportunities to reconstruct modern facilities and to strengthen and reinstate their relationships with their stakeholders. Monsanto can learn vicariously and copy from these examples.

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**Chapter
7
Biological Terrorism
and the Local
Community:
Communication Needs
and Response**

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This chapter uses the example of a religious community's Salmonella virus attack on an Oregon community to outline practices local communities can employ to prepare for and respond to this and other types of crises. In 1981, the religious community known as the Bhagwan Shree Rajneesh purchased a 100-square-mile ranch south ranch in Wasco County, Oregon. The Rajneesh incorporated their commune as a city. For many members, this was the fulfillment of a dream: to build Rajneeshpuram (i.e., the city of Rajneesh), a city sacred to the cult, "America's first enlightened city" (Martin, 1992, p.356), and the new international headquarters for the movement. When construction of the commune ran into zoning problems, the Rajneeshees decided the upcoming elections provided an opportunity to change the makeup of the county commission, thus reducing opposition to their obtaining permits and clearing the way for their plans to move forward. In order to win the county election, the Rajneeshees developed two plans.

When construction of the commune ran into zoning problems, the Rajneeshees decided the upcoming elections provided an opportunity to change the makeup of the county commission, thus reducing opposition to their obtaining permits and clearing the way for their plans to move forward.

The first plan involved moving over three thousand homeless persons to the ranch, to take advantage of Oregon's liberal voter registration laws. However, before the registration period closed county officials noticed an increase in voter registration. Suspecting something, the county required all newly-registered voters take part in a questioning session. This persuaded the Rajneeshees to try another plan.

About this time, a total of 751 persons became ill with Salmonella gastroenteritis (Tucker, 1999; Torok, Tauxe, Wise, Livengood, et al., 1997). The outbreak occurred in two waves, from 9 through 18 September and 19 September through 10 October. The majority of cases were associated with ten restaurants. Epidemiologic studies of customers at four restaurants and of employees at all ten restaurants pointed to contaminated salad bars as the major source of infection. Eight of the ten affected restaurants operated salad bars; only three of the 28 other restaurants in The Dalles had salad bars (Torok et al., 1997). The implicated food items on the salad bars differed from one restaurant to another.

On 17 September, the local public health department received a call from someone who reported falling ill from gastroenteritis after eating at a restaurant in The Dalles. Over the next few days, twenty more instances were reported to the Health Department. After two days, a pathologist at the Mid-Columbia Medical Center discovered Salmonella was the cause of the outbreak. Four days later, a Portland scientist identified the strain as Salmonella Typhimurium, an unusual form of the bacteria, but treatable with most antibiotics (Miller, Engelberg & Broad, 2002).

An extensive examination of food handlers at several local restaurants; local cattle, fruit, and dairy farms; and the city water supply, concluded that the contamination was unintentional. In a 1985 preliminary report, Tom Torok, a member of the Center for Disease Control and Prevention's Epidemic Intelligence Service, stated:

[Federal scientists were] unable to find the cause of the outbreak and that food handlers were probably to blame. Because workers preparing the food at the affected restaurants

had fallen ill before most patrons had, the report reasoned, and because some minor violations of sanitary practices at a few restaurants had been detected, food handlers “may have contaminated” the salad bars. (Miller, Engelberg & Broad, 2002, p. 23)

Although some in The Dalles believed the Rajneeshees were responsible for the outbreak, this hypothesis could not be supported. It was not until over a year later that evidence emerged linking the Rajneeshees to the attack. The cult’s leader, the Bhagwan, accused particular members of the attacks and of

conducting tests to conspire to commit more attacks. A new investigation found invoices from the American Type Culture Collection, supporting the accusations that Salmonella had been grown at the Rajneeshees ranch.

This case demonstrates that in bioterrorist attacks, as in many crises, detection and the rapid response to the attack will be difficult.

The 1984 attacks were, in fact, only a test, a trial run before the election. Those involved had taken the Salmonella from the ranch to The Dalles and had contaminated lettuce in the local grocery store and in coffee creamers, blue-cheese dressings, and fruits and vegetables at restaurant salad bars.

This episode still remains the most widespread, bioterrorism attack in U.S. history. The event did not receive much attention (both media and government) for a number of reasons. First, because it was a biological attack, the characteristics exhibited during the episode allowed it to be interpreted as a natural occurrence, which did not cause the fear a biological attack would. Second, because the attack was believed to be of natural origin, it did not seem newsworthy. The heightened fear of terrorism now manifest in the United States, did not exist prior to 9/11. Moreover, the 24-hour news channels that now cover such an event were not as common. Third, without the presence of a trigger event indicating a crisis had begun it was difficult for the crisis to achieve media attention.

This case demonstrates that in bioterrorist attacks, as in many crises, detection and the rapid response to the attack will be difficult. These issues are examined in further detail in the next sections.

Defense vs. Preparedness

Preparing for crises is important because it forces individuals and communities to begin thinking about possible outcomes and consequences. Further, defensive procedures help to reassure the public, providing them a sense of security that “something is being done.” However, defense is not absolute, and past terrorist events have demonstrated that those intending to cause harm will discover novel and unpredictable means to inflict that harm. Research working towards preventing a bioterrorist attack must continue, since preparedness to act after such an event can help to minimize the scope, duration and the level of harm of the event. The following are suggestions on how local communities can use existing communication channels and create new channels to communicate during such an event. In addition, message designs are offered.

Crisis and the Local Community

Any discussion of the role of local response outlets in alleviating fear and uncertainty during times of imminent danger must begin with a discussion of the

definitional and theoretical criteria surrounding crisis and risk communication. Crisis communication scholars have defined crises as “specific, unexpected, and non-routine event or series of events that create high levels of uncertainty and threaten or are perceived to threaten high priority goals including security of life and property of the general individual or community well being” (Seeger, Sellnow & Ulmer, 1998, p.233). Weick’s (1995) critique defines crisis scenarios as “low probability/high consequence events that threaten the most fundamental of goals of the organization. Because of their low probability, these events defy interpretations and impose severe demands on sensemaking” (p. 305). Since by definition crisis situations are unexpected and alarming, they typically lead to an increase in stress, fear, and uncertainty among those who are immediately affected. In the cases of local crises such as bioterrorism, the strongest levels of fear and uncertainty will not be confined to those areas in which people may be physically threatened by the event.

A poorly constructed response can create confusion and, potentially, worsen the public reaction. In some cases, recommendations made by public agencies have actually increased the harm.

Consistent with past work in social psychology, individuals are compelled to seek out certainty, resolution, and the restoration of predictability to their surroundings. This drive to reduce uncertainty, a negative and unpleasant state of arousal and cognition, is a basic consequence of any crisis (Berlyne, 1960). The basic need to seek out additional information is especially strong in instances such as bioterrorism events, when the outcomes associated with the crisis may be extremely harmful (Heath & Gay, 1997) and these potential risks are almost completely uncontrollable (Miller, 1987).

Crisis have historically been typified as situations that begin with a clear trigger event indicating the crisis has begun. However, in the case of more localized crises of biological origin, it is plausible that a clear and dramatic trigger (such as planes hitting the towers on 9/11) may not be evident, and that the existence of the crisis may evolve over days or weeks as initial information is accumulated (such as reports of widespread illness or death). In the absence of a trigger event, the realization or official declaration of a crisis will be interpreted as an indication that the current conditions are moving in an unpredictable direction which is inconsistent with routine events and procedures. Crisis then continues until a resolution is achieved.

Further, individuals tend to engage in information-seeking when faced with uncertainty (Brashears, Neidig, Haas, Dobbs, Cardillo & Russell, 2000). Media outlets can be expected to be the primary resource for obtaining this information (Murch, 1971), especially at the local level. The public need for information requires that communication during and about the crisis must be highly specific, ordered, and distributed through localized media that reaches those who most need the information: those directly affected and perceiving potential hazards.

The initial response to a crisis has several consequences, potentially positive and negative. A poorly constructed response can create confusion and, potentially, worsen the public reaction. In some cases, recommendations made by public agencies have actually increased the harm. Information during a local crisis must address both the crisis and the risk involved. Peter Sandman et al. (1998; 2003) has suggested that in these circumstances, communication is made up of two components: “scaring people” and “calming people down.” Put another way, messages are intended to both alert and reassure people.

Sandman further posits that crisis and risk communication attempts to establish a level of outrage that is appropriate given the level of hazard, loosely expressed through the following formula: Risk=Hazard+Outrage. Hazard may be thought of in terms of the tangible seriousness of a risk, such as loss of life or serious illness, while outrage refers cultural seriousness including uncertainty, anger, and perceived assault on one's community (Sandman, 2003). If the public is outraged because it doesn't understand the hazard, it must be educated on the nature and extent of the hazard associated with the incident. If the hazard is understood, the outrage must be addressed.

Addressing Issues and Perceptions of Hazard

Messages addressing hazard and outrage must also satisfy the public's need for control, outlining steps that individuals can take in order to reduce their susceptibility to risk (hazard).

The concern that may be the most central to a crisis event is the speed of response. The speed of the response is one measure in reducing the uncertainty that will arise within the local population. In a crisis, local communities are expected to respond to

disasters and emergencies using their own resources. Where the community lacks adequate capacity, they solicit assets from the state and neighboring jurisdictions. State and federal resources are in only after local governments discover they lack adequate capacity and therefore, request assistance from the federal government.

Messages addressing hazard and outrage must also satisfy the public's need for control, outlining steps that individuals can take in order to reduce their susceptibility to risk (hazard). Messages that focus on the public's susceptibility to risk will create fear, reducing the individual's capacity to make rationale decisions related to the situation (Aspinwall, 1999). Risk communication in localized crises should provide fear-inducing messages containing an appropriate degree of hazard and outrage, and then inform the public of practical steps they can take. Inaccurate communication of the risk factors involved will inhibit individuals from making choices that are rational in addressing these risks. Further, risk messages must address outrage appropriately in order to maintain audience attention.

After individuals have obtained the desired information, they will frequently continue to scan available media seeking repetition of the same message. In the case of localized crises, these responses may be explained in one of two ways: First, repeated exposure to the message may act as a calming agent, reducing uncertainty; and second, continual media scanning may be an attempt to reduce dissonance. This magnifies the importance of repeating messages with the goal of calming and reducing potential outrage. For example, following 9/11 New York City Mayor Rudolph Guiliani held press conferences at regularly scheduled intervals over the next few days. Often, he possessed little or no new information, but repetition of known facts helped calm the public and reassure those directly affected that events were under control.

The local community should have a pre-existing relationship with federal agencies. The federal management of a domestic crisis falls under the jurisdiction of the Federal Bureau of Investigations (FBI), but when the role of the FBI ends coordination is handed over to Federal Emergency Management Agency (FEMA). National defense planning for civil emergencies involves the FEMA, which will also handle much of the federal coordination. FEMA was given this authority under the Stafford Act (Public Law 93-288). The Department of

Defense participates in emergency response planning and supports functional groups of the Federal Response Plan, but the branches of the U.S. military cannot be used for enforcing U.S. laws or aiding civilian law enforcement and therefore will serve more of a support and labor role. Because such issues of national scope and coordination will be handled by federal agencies, the local response structure should focus on meeting the needs and desire of the immediate community and while still working with federal agencies, yielding the responsibility of worrying about communication of information on a regional or national scale to federal agencies. The local structure should work closely with federal agencies to aid in response and coordination, but worry first about communicating to its own stakeholders (the local community where the bioterrorist outbreak has occurred).

Another reason local agencies need to have pre-existing relationships and response plans ready is the issue of convergence. In a biological event, for example, people, goods, and services will be spontaneously mobilized and

sent into the local community. This convergence of resources will have beneficial effects, but it may also lead to congestion, confusion, retard the delivery of aid, and waste scarce resources.

Individual audience members will likely worry about the recurrence of similar events in close proximity to the initial crisis. Information provided must both be as accurate as possible and disclose all available information about the situation. Under these circumstances, the public needs an accurate assessment of the probability of second event and instructions on what they should do should a second event take place. Often, in these instances, the temptation is to downplay or withhold potential information concerning hazard. This should be avoided, as past crisis research suggests that the public won't panic, and may actually respond more negatively to information that is perceived to be distorted or incomplete. For example, in the aftermath of the 1986 Challenger explosion the public was given numerous different accounts of the crisis from different sources and stakeholders; public reaction was characterized by both confusion and frustration (Seeger, 1986).

If the public communication of accurate information is followed by detailed instructions on a pragmatic response that can be employed, the public will likely follow those instructions. The ability of individuals directly affected by a crisis to make reasoned decisions is seriously reduced in comparison to everyday or normal conditions. Enabling people to take tangible measures will lead to a sense of empowerment, creating an impression that the affected individual has some kind of control over the situation (Seeger et al., 2002).

Addressing Issues and Implications of Outrage

A localized crisis such as a bioterrorism incident can be expected to produce fear and create uncertainty. A crisis of this nature has a good chance of both directly affecting persons (high hazard) and them (high outrage). Messages in the aftermath must then be directed at this outrage and at the fear that may actually be increased by simple news coverage. Outrage is the relative cultural seriousness due to the risk, or how frightened, angry, or upset people become due to the crisis. The correlation between the hazard (how many

In a biological event, for example, people, goods, and services will be spontaneously mobilized and sent into the local community. This convergence of resources will have beneficial effects, but it may also lead to congestion, confusion, retard the delivery of aid, and waste scarce resources.

people are killed or harmed by the risk) and the outrage (how many people the risk upsets) may actually be fairly low. Messages constructed to inform area individuals about the hazard must also address outrage. The induced outrage must be to a degree strong enough to encourage the vulnerable public to act upon the hazard, yet ensure that the public does not experience a collapse in sense-making.

Furthermore, in considering different component groups of a local audience, there is evidence that differences between males and females must be addressed in terms of their information-seeking tendencies. Hoffner, Fujioka,

Ibrahim, and Ye (2002) report that males are more likely to experience outrage reactions that may manifest themselves in behaviors or behavioral advocacy.

Primacy of messages must also be considered. The first message received by the public generally sets the standards and expectations for future messages dealing with that particular crisis (CDC, 2002). In order to minimize potential negative outrage, the message breaking news of a developing crisis must be as accurate as possible, even

if maintaining accuracy means indicating that there is much about the crisis that is unknown. Subsequent messages that later provide further information will inevitably be compared and acted upon through comparisons to the first message.

The public must know that a tangible behavioral response to the crises exists. Providing the public with such a response helps to reduce feelings of helplessness, fear, and isolation. Thus, the facts, level of hazard, and the recommended actions must be accurately presented when responding to a localized crisis. Additionally, behavioral recommendations should be framed in a positive light (CDC, 2002). For example, if people affected by a bioterrorist incident are to shelter-in-place, the message should be framed by stating, stay in the safety of your home, rather than don't go outdoors.

Federal agencies will have communication networks in place to deal with the national media; however, it is appropriate for the local community to provide a spokesperson to be the voice of the event. The situation may dictate that the local spokesperson will not act as the national spokesperson. Rather, the federal agencies will provide such a person. In the case of a biological attack, for example, the information needs of those in close proximity to the event will differ from those more removed from the area. As noted in Spence et al. (2005), individuals in close proximity to the site of the 9/11 attacks reported greater fear than those farther away, and the information needs and desires were different. In the three locations studied (Detroit, Fargo, and Little Rock), Little Rock was the only location in which respondents stated a desire for reassuring information from both political leaders and religious leaders, while those closer to New York (Detroit) reported the media as being more useful for their needs.

After such an event, many in the local community may become fixated on media forms to obtain information about several specific aspects of the event. In the aftermath of a crisis, messages are both post-crises and risk communication in nature. Selecting the medium at this point is contingent on

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several of the previous listed factors and is dependent upon what is available. Television is more brittle than radio. Often when television is “off the air” many radio stations are still broadcasting. During the 1997 Red River Valley flood in Minnesota and North Dakota, for example, an AM station in Fargo, North Dakota, was powerful enough to broadcast throughout the entire Red River Valley region.

[The station] dedicated its format almost entirely to flood coverage during the period when the river was at flood stage. Residents were invited to call the station and broadcast their appeals for sandbagging assistance live. This allowed for the highly efficient movement of human resources throughout the flood region. The station invited city officials and representatives from support agencies to broadcast their messages at will. (Sellnow et al., 2002, p. 282)

Although the brittleness of television may not be a factor during a biological event, the use of radio still might serve several needed functions. First, radio, more so than television, will allow several members of the local community to share stories. Second, radio can provide information that is specific to the local community, whereas television during this period may be providing news coverage to the broader audience, most of which is not in close proximity to the event. Thus, the types and scope of the information covered may be very different between the two mediums.

This chapter used the example of a bio-terrorist attack on an Oregon community as a vehicle for discussing practices community leaders and response teams may consider when preparing for and responding to all types of food related crises. The lessons learned may provide guidance in the event of future acts of intentional contamination within the American food supply.

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Chapter

8

From Farm to Fork: Communication and Best Practices in Food Safety

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Food safety is a recurring question, both as an issue management challenge and as a crisis communication imperative. Since the industrialization of food production and processing in the late 1800s and early 1900s, questions of food safety, purity, and quality have been endemic to the industry. The 1886 debates over the oleomargarine bill epitomized these concerns. As the debate became a public relations campaign, the dairy industry lobby made vivid charges that margarine was manufactured using diseased cattle, horses, hogs, and even cats. Widespread public concern was generated and legislation followed. Similarly, Upton Sinclair's portrayal of the meat packing industry in the 1906 novel, *The Jungle* raised fundamental questions about industrial-scale food production. Outbreaks of food borne illness, however, are most often traced to the home or small production facilities. Comparatively speaking, widespread industrial outbreaks are rare, although, as the articles in this volume indicate, they can be expected to generate widespread media attention and public concern.

This extended chain of production, often expressed with the phrases, "From farm to fork," or "From seed to shelf," creates vulnerabilities.

While the food supply in the United States is one of the safest in the world, the CDC estimates that 76 million people get sick, more than 300,000 are hospitalized, and 5,000 Americans die each year from food borne illness (Mead et al., 2000). More than 200 known diseases are transmitted through food. In addition, food is susceptible to unintentional and intentional contamination by a wide range of other agents. Only in a very few documented instances has the food supply been intentionally contaminated, although the threat of such contamination is very real, particularly in a post 9/11 environment. The vulnerability of the food supply is a recurring theme in public discourse.

This volume explores six cases of food borne illness outbreaks and questions about contamination; the first four of which were accidental. This chapter outlines recurring themes and identifies overlapping concepts in these case studies. In addition, the role of communication in response to these events is explored and the issue of food borne illness is contextualized using principles of chaos theory.

Food Production as a Complex System

Recent effort to understand crises and disasters has drawn heavily on the principles of complex systems theory or chaos theory (Perrow, 1984; Seeger, Sellnow & Ulmer, 2003). These approaches emphasize the dynamic and non-linear nature of highly complex systems. As systems become larger, more complex and more tightly coupled, the probability of an unforeseen interaction increases. Such interactions have the potential to create a crisis, or what system theorists call bifurcation. When bifurcation occurs, the system is fundamentally altered in some dramatic way.

Complex systems also defy precise prediction. That is to say, they often perform in very unexpected and unanticipated ways. In addition, chaos theory emphasizes that even very small variance in a system has the potential to lead to large-scale, unforeseen consequences. What appears initially as a very small oversight, or insignificant issue can quickly create serious and even devastating outcomes. The cases discussed in this volume illustrate the performance and bifurcation of complex systems.

The modern food production system is increasingly dynamic, integrated, tightly coupled, and complex. From agricultural production systems on farms, orchards, and ranches, through processing in industrial settings to

transportation, distribution, wholesale and retail outlets on to the consumer, preparation and consumption, modern food production is very susceptible to systemic breakdowns. This extended chain of production, often expressed with the phrases, “From farm to fork,” or “From seed to shelf,” creates vulnerabilities. Large-scale production and width of distribution has added to the complexity and increased the chances that an adverse event will be widespread. Greater emphasis on efficiency and smaller profit margins has reduced slack resources and buffers that may reduce or contain crises. The use of technology, such as automated production, while reducing some threats, has introduced others and enhanced overall complexity. Finally, globalization of food production and distribution has added additional levels of complexity and reduced levels of predictability. In the global food market, food is produced under a very wide range of regulatory, cultural and economic contexts. These features of the food production and distribution system are all illustrated in the cases presented here.

Effective communication is particularly critical to the successful management of food borne illness in at least three specific ways.

The Role of Communication in Response

The food production and distribution systems face a relatively specific set of risks. As noted earlier, these relate primarily to the outbreaks of food borne illness due to some kind of systemic contamination. While the range of agents is potentially quite large, most food borne events involve one of about four agents. The most common food borne infections are those caused by the bacteria *Campylobacter*, *Salmonella*, and *E. coli* 0157:H7, and by the calicivirus, or Norwalk viruses (CDC, 2005). Other relatively common agents are listeria, shigella and Hepatitis A. Before modern food processing technology, botulism was also a serious threat, primarily from home canning operations. The introduction of pasteurization of milk helped eliminate the transmission of brucellosis and tuberculosis. In addition to these agents, food can be contaminated with a wide array of other infectious agents. In some cases, food additives have been shown to be dangerous and in rare cases, unintentional contamination with chemical agents has occurred. The kind of agent, level of exposure, and the number and relative health of those exposed are significant factors in the level of threat.

Effective communication is particularly critical to the successful management of food borne illness in at least three specific ways. First, outbreaks of food borne illness are more likely to be contained when there is timely identification of the agent. This requires not only carefully disease monitoring, usually by public health departments, but also effective communication and coordination across agencies and often among producers. Any delay in identification and notification can enhance harm. Coordination in such circumstances can be particularly challenging. Second, an effective response often requires that the contaminated food be withdrawn from distribution. Timely recalls require effective public communication, usually through the media. With extended distribution channels and the processing of food into other food products, such recalls are often incomplete. Finally, a food borne illness outbreak will also require effective post-event communication. Most often, this post-event communication takes the form of image restoration strategies, although explanations and accounts also follow an outbreak of food borne illness. Effective post-crisis communication is also necessary for organizational learning.

Recurring Themes

The chapters featured in this volume explore a range of food borne illness outbreaks and the associated communication strategies. Some, such as the Schwan's salmonella outbreak, are examples of successful crisis communication and response. Others, such as Chi Chi's Hepatitis A event, were handled very ineffectively. Most are unintentional episodes, although some represent cases of clear negligence while one case involved intentional contamination. The case of Monsanto's genetically modified wheat is the clearest example of an issue management challenge rather than a fully developed crisis episode per se. Only in the case of contaminated salad bars in The Dalles, Oregon was the episode

intentional. Within this range of cases, there are several important recurring themes

First, as noted earlier, these cases all illustrate the complexity of the food

production and distribution system and the tendency of this system to interact in unexpected, crisis-inducing ways. Two of the cases in particular, illustrate the role of imported food products in outbreaks of food borne illness. In addition, the Monsanto case demonstrated the risks inherent to new, complex technology, particularly when poorly understood by the public.

A second recurring theme is the role of ethics, social responsibility and organizational legitimacy. Legitimacy is also affected by previous beliefs, attitude and reputations. Crises inherently strip an organization down to its core values. Crises highlight these values and make them visible to stakeholders. If an organization privileges profits over safety, for example, these priorities are often starkly evident following a crisis. Research suggests that the most effective responses to a crisis are principled responses. In addition, a crisis calls into jeopardy the social legitimacy of an organization and requires some effort to reestablish legitimacy. This effect is particularly strong when the organization is clearly culpable in the outbreak. Several of the cases reviewed in this volume explore image restoration techniques as approaches to repairing damaged legitimacy.

An interesting third theme that emerges from the cases explored here is the role trust plays in food. Food is a very intimate product. Because food is consumed, a perception that food is somehow unsafe or impure is particularly harmful. Moreover, food borne illness that impacts vulnerable populations, such as children, may have particularly profound effects on an organization's reputation and legitimacy. The cases of Jack in the Box and tainted strawberries in school lunches illustrate this effect. Because of the intimate nature of food, trust and reputation is particularly vulnerable. Stories of tainted food if not effectively managed can become powerful narratives, even taking on the status of larger social themes.

A fourth theme emerging from these essays concerns organizational learning. Learning is the desired outcome of a crisis because it allows the organization to move beyond the event as a stronger, more resilient system. Unfortunately, most organizations experience failed learning following a crisis. Lessons are not understood, communicated successfully, or retained. The consequence is that many crises occur again.

Discussion of Cases

In "Social Responsibility: Lessons Learned from Schwan's Salmonella Crisis," McIntyre explores the important case of Schwan's salmonella outbreak. Schwan's is widely regarded as a model of effective crisis communication

Research suggests that the most effective responses to a crisis are principled responses.

following a food borne illness outbreak. Specifically, McIntyre explores the intersection of crisis communication and ethics in the form of social responsibility. This case also illustrates the critical role of trust in episodes related to food.

Schwan's had a long-standing reputation as a responsible organization with a clear commitment to its customers. This analysis suggests that Schwan's reputation and positive stakeholder relations both provided a resource the company could draw on and informed the organization's response. The role of a reservoir of good will in crisis response has been demonstrated elsewhere. In addition, companies as diverse as Johnson and Johnson, with its Tylenol episode, and Malden Mills, with its manufacturing facility fire, have used values and ethics as the cornerstone of an effective crisis response. In general, these principled, value-based responses appear to be more effective than responses based merely on economic values. Although sorting out the relationship between social responsibility, legitimacy, and corporate citizenship is beyond the scope of this analysis, subsequent efforts should be focused in this area.

In addition to demonstrating the role of values and ethics in effective response, Schwan's also illustrates the role of complexity in the food production and distribution system. In this case, the intersection of transportation systems and outside suppliers caused the contamination. Suppliers always have the capacity of creating unforeseen variance and transportation is a vulnerable link in the farm to fork chain. It should also be noted that while Schwan's responded effectively, the salmonella outbreak was comparatively minor. A different agent and/or more serious customer harm may have overwhelmed the company's reservoir of good will.

The third chapter in this volume is a powerful contrast to the successes of Schwan's. Chi Chi's outbreak of Hepatitis A associated with contaminated green onions imported from Mexico includes a number of very serious crisis elements combined with ineffective responses. Moreover, at the time of the outbreak, the company was already in a vulnerable position. The result was a kind of perfect storm that ultimately led to the closing of the restaurant chain.

Sjoberg's telling of the Chi Chi's story begins with the extended supply chain and global independence in the food distribution system. Green onions grown in Mexico were produced, it was later found, under unsanitary conditions. The ways in which the onions were shipped and stored allowed for further contamination of the onions making the virus more difficult to remove by washing. This incubating effect is commonly found as a factor in a crisis. In this case, the international sourcing of the onions added a level of complexity.

The agent involved, Hepatitis A, is potentially a very serious disorder. Transmitted through the fecal-oral route, Hepatitis A is a viral agent that causes liver damage. The medium incubation period is 28 days. The CDC reports that in 28% of the cases of food borne Hepatitis A outbreaks, the sources are never identified (Fiore, 2004). In this case, the extended incubation and the processing of the onions into salsa and dip made it difficult to track the source. Thus, customers continued to be contaminated and warnings and recalls were not timely, and the efficacy of vaccinations was reduced. The Chi Chi's outbreak ultimately accounted for three deaths and over 700 people became ill.

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Also complicating the response was the fact that Chi Chi's parent company was in bankruptcy proceedings at the time of the outbreak. The viability of Chi Chi's was already in question and the Hepatitis A outbreak served to further undermine the company. Coombs has described the impact of multiple crises using the metaphor of Velcro. A previous crisis creates a condition where the

magnitude of subsequent events is enhanced. In this case, the ability of Chi Chi's management to mount an effective response was seriously limited.

Sjoberg notes that Chi Chi's undertook many appropriate image restoration strategies, but ultimately the company

Moreover, this acknowledgement of responsibility is necessary for organizational learning to occur. This relationship is not generally emphasized in the crisis communication literature and represents an important link in effective crisis response.

failed to survive. She suggests that the company was too slow to shift blame to its Mexican suppliers. Several additional facts, including scope and scale, the already tenuous state of the company contributed to this failed effort at apology and image restoration.

The third case explored here, the E. coli 0157 outbreak from Jack in the Box hamburgers is approached from the perspective of learning. Littlefield suggests that the crisis led Jack in the Box to recognize the need to accept responsibility and develop a crisis management plan. Like Chi Chi's, this was a major event involving a serious agent and organizational culpability. In this case, E. coli 0157 was present in tainted hamburger. Inadequate cooking procedures failed to kill the agent and ultimately, 400 people were treated and three people died. The outbreak had a disproportional impact on children, probably because of the nature of the Jack in the Box customer base and because children are more susceptible. Like the Chi Chi's episode, the initial outbreak was attributable to suppliers. Jack in the Box compounded the harm through the relatively small error of inadequate cooking temperature.

Littlefield notes that the ability to respond was hampered by lack of a crisis communication plan and that the initial efforts were characterized by blame shifting and ambiguous responses. Only when these responses proved inadequate did the company acknowledge its culpability. This compounded the crisis because not only did Jack in the Box need to account for its role in the outbreak, but it also needed to explain its inadequate response. This public backtracking damages the organizations credibility and is a needless distraction during a crisis.

It is interesting to note that while Sjoberg suggested Chi Chi's was deficient in shifting blame, Littlefield argues that Jack in the Box management was too quick to shift blame. Moreover, this acknowledgement of responsibility is necessary for organizational learning to occur. This relationship is not generally emphasized in the crisis communication literature and represents an important link in effective crisis response. Compelling evidence is provided that Jack in the Box did learn from this event.

The fifth chapter in this volume again involves Hepatitis A, but this time in tainted strawberries used in school lunch programs sponsored by the USDA. This case reiterates important themes described in earlier chapter and introduces others. The case again illustrates the role of complex food processing systems and food produced in other countries. In this case, the harm was

compounded by the relatively small error in mislabeling of the strawberry's country of origin allowing them to be used in the school lunch program. Later investigations suggested that the mislabeling was intentional. As with Chi Chi's onions, these strawberries were grown in Mexico under unsanitary conditions. As with Jack in the Box, the impact on children was disproportional. Some 231 children and teachers were affected.

In this chapter, Novak emphasizes the role of coordination and cooperation in post crisis response. She notes, "When crisis in food safety occurs, communication plays a pivotal role." Moreover, agencies and organizations must

coordinate and cooperate with one another to both track down the source of the outbreak and contain the harm through warnings and recalls. In this case, coordination included the USDA, the CDC, the Michigan Department of Public Health, Andrews and Williams Sales, Inc., and several food vendors. The resulting complexity,

as well as failures to acknowledge and accept the initial warnings, slowed both recognition and response. Although the Michigan Department of Public Health and the CDC were able to identify the probable source of the outbreaks within four days, strawberries were still being served in school lunches three days later and were in the distribution system for at least 20 more days. In this case, the extended distribution system from the farm to the fork made recalling the strawberries a daunting task. The task was compounded by lack of cooperation and small errors.

Novak concludes by emphasizing the importance of planning in an effective response. While planning is important in achieving effective coordination, it is also the case that coordination and cooperation can occur spontaneously during a crisis. This spontaneous self-organization, however, has not generally been documented in the response of complex bureaucracies to crisis conditions. Research should be directed to identifying ways in which communication, cooperation, and coordination can be facilitated.

The case of genetically modified (GM) wheat and the Monsanto Corporation described by Lyonga is a departure from the kinds of food borne illnesses described in earlier cases. No one became ill from Monsanto's GM wheat and in fact, the product never reached market. Rather than a crisis per se, this case represents an issue management challenge faced by an organization seeking to introduce a new food and new food production technology.

As Lyonga notes, generic modification of agricultural products is very controversial. Although spokespersons for GM companies such as Monsanto regularly discount any problems and emphasize the potential of GM technology to radically increase food production and reduce the need for chemicals, skepticism remains. Most of this skepticism comes from consumer and environmental groups as well as the organic food community. Recently, international organizations and agencies seeking protection of sustainable agriculture have also expressed concern. Critics point out that too much is simply unknown and that unforeseen consequences can occur.

Lyonga uses diffusion of innovation theory to explore the case of GM wheat.

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Developed primarily through the work of Everett Rogers, this approach seeks to facilitate the engineering of adoption of new products and innovations. While diffusion of innovation works very well for those innovations, which are largely uncontroversial, it breaks down where there are powerful counter arguments and active special interest groups working against the new technology.

A significant body of research in risk communication has demonstrated that novel and exotic issues are perceived as more risky than those that are familiar. A familiar risk is, after all, more predictable. In the case of GM wheat, not only is the product novel and exotic, but also the alterations cannot be seen. GM technology has been described as defying the laws of nature to create Frankenfood. It is not surprising, then, that GM is viewed by many as very risky.

Through the Monsanto case, Lyonga demonstrates the problem of seeking to engineer acceptance of a new technology. Monsanto's tactics were heavy handed and the company refused to acknowledge the legitimacy of concerns until far too late. Ultimately, after widespread domestic and international protests, the company abandoned plans to commercialize GM wheat. Other approaches, such as issue management or even a risk-sharing model may have led to a different process and outcome.

Finally, Spence and Lachlan explore a case of intentional food contamination by the Bhagwan Shree Rajneesh cult in Wasco County, Oregon. In 1981, the community numbered about 7,000 followers. In an effort to influence the outcome of a local election, cult members contaminated salad bars in local restaurants with a strain of salmonella. The contaminated foods differed from salad bar to salad bar, making identification of the source difficult. Although some suspected the Rajneesh cult, initial reports failed to identify the source and concluded that the outbreak was unintentional. It was not until much later, when a dispute arose among cult membership that the nature of the outbreak was confirmed. In the subsequent investigation it was determined that the salmonella bacteria had been grown at the Rajneeshees ranch.

A number of issues regarding preparation are also explored in this last case study. Spence and Lachlan describe several specific kinds of actions and communication processes that help mitigate and contain the harm a local community might experience. In addition, they discuss the social and psychological outcomes that might arise from a widespread, intentional event. Although little evidence exists as to what specific outcomes might occur, it is likely, as the authors note, that high uncertainty, fear, and outrage would accompany an intentional contamination. In addition, the faith of the public in the security of the food supply would likely be compromised.

Conclusion

Food borne illness is not certainly a recent phenomenon. People have been getting sick from eating contaminated food for as long as people have been eating. Moreover, modern production techniques have dramatically reduced the number of incidents. The advent of new, more complex food production and distribution systems, the globalization of the food supply, the phenomenon of intentional contamination and intense media coverage has significantly enhanced the profile of outbreaks. The reputation of specific organizations and industry sectors may be seriously affected by widespread events. In addition, there is a very real potential of widespread harm. It is likely that more events and more widespread events will continue to occur. Successful management of these events, through communication and recognition of warnings, through

public notification and recalls, and through post events is increasingly important.

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Afterword

Risk+Crisis Communication Project

Project History

The Risk+Crisis Communication Project (RCCP) began at NDSU in 2000 with funding from a cooperative agreement with the United States Department of Agriculture-Animal Plant Health Inspection Service. The program expanded with additional funding and research opportunities from the USDA, Centers for Disease Control and Prevention, and Department of Homeland Security. At the present, the RCCP is affiliated with the Great Plains Institute for Food Safety and the National Center for Food Protection and Defense.

The Risk+Crisis Communication Project

- Seeks to unify a series of research opportunities in the consistent mission of developing best practices.
- Engages in research that is intertwined with education. The research, conducted from a variety of angles, seeks to identify best practices.
- Research process affords undergraduate, masters, and doctoral students an educational opportunity in risk and crisis communication.
- The product of the research, a rubric of best practices, serves as the foundation for education, training, and consulting with government agencies and private industry.
- Serves as an educational resource designed to inspire ethical risk and crisis communication that meets the constraints of high risk and crisis situations in a product efficient manner.

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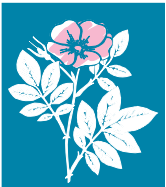
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